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Deliberate Self-Harm in Mental Health Inpatient Settings

by

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**Thesis submitted in partial fulfilment of the requirements for the
degree of Doctor of Clinical Psychology**

**University of Warwick, Department of Psychology, and Coventry
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Declaration

This thesis has been written for submission as partial fulfilment of the requirements for the Coventry University and The University of Warwick Clinical Psychology Doctorate Programme, and has not been submitted in support of an application for another degree at any other university or institution. The thesis is the candidate's own original work, carried out under the supervision of Jacky Knibbs and Dr. Malcolm Wheatley.

Summary

Deliberate self-harm is a significant phenomenon amongst people in the general community, and is particularly prevalent amongst patients being treated in mental health inpatient settings. Views that staff hold towards patients who self-harm could have an impact upon the care and interventions that are delivered. The focus of this thesis was deliberate self-harm within inpatient mental health settings. The literature review presented in Chapter 1 provides an overview of previous reviews of studies that have evaluated psychological interventions for deliberate self-harm. All recent relevant evaluative studies of psychological interventions predominantly aimed at reducing deliberate self-harm, or treating self-harm as part of the symptomatology of Borderline Personality Disorder, amongst inpatient environments are then critically reviewed. The results of this are discussed along with clinical implications for practitioners working in mental health inpatient settings and recommendations for future research. The focus moves to staff attributions towards deliberate self-harm in inpatient settings in Chapter 2. This chapter presents empirical findings, reporting on adaptations of attributional and knowledge measures, and analyses of responses to these measures provided by qualified and unqualified nursing staff participants working in an inpatient setting. Questions regarding training needs were also posed, and participants were given the opportunity to comment on working with people who self-harm. Chapter 3 presents a reflective paper, incorporating references from literature, poetry and music, providing reflections on producing the first two chapters of the thesis, and on the overall experience of completing research for the clinical psychology doctorate course.

List of Abbreviations

A & E – Accident & Emergency
ANOVA – Analysis of Variance
APA – American Psychiatric Association
BPD – Borderline Personality Disorder
CC – Creative Coping
DBT – Dialectical Behaviour Therapy
DSH – deliberate self-harm
DSM-IV - Diagnostic and Statistical Manual of Mental Disorders-IV
EMDR – Eye Movement Desensitization & Reprocessing
ICD-10 - International Classification of Diseases-10
LT – long-term
MANOVA – Multivariate Analysis of Variance
NICE – National Institute of Clinical Excellence
PTSD – Post Traumatic Stress Disorder
RCT – randomised controlled trial
RMT – Relationship Management Therapy
SFT – Schema Focused Therapy
ST – short-term
TAU – treatment as usual
TFP – Transference Focused Psychotherapy
WHO – World Health Organisation
W & L – Wellness & Lifestyle

Chapter 1: Literature Review

Psychological Interventions for Patients Presenting with Deliberate Self-Harm in Mental Health Inpatient Settings: A Review

Word Count – 7998 (excluding tables and references)

1.1 Abstract

Deliberate self-harm (DSH) is linked to other factors such as mood and suicidal intent, and in many cases symptomatology of personality disorders, and therefore interventions for DSH have often also addressed these difficulties. Previous reviews have focused on the effectiveness of interventions for DSH in all environments, predominantly reviewing outcomes of community intervention studies, often with individuals considered to meet the criteria for Borderline Personality Disorder. An overview of ten previous reviews is presented. The current review identifies all 22 recent relevant outcome studies of interventions for mental health inpatients displaying DSH. The majority of studies have produced positive results in terms of reducing DSH frequencies and related measures, although this is not true in all cases. The results of this review are discussed along with clinical implications for practitioners working in mental health inpatient settings and recommendations for future research, taking into account individual differences.

1.2 Introduction

1.2.1 Aims of the current review

There is growing literature on evaluations of intervention strategies aimed at reducing self-harming behaviours. However, to date most of this has discussed the application of interventions with people living in the community. There is a much smaller evidence base regarding psychological intervention for self-harm in mental health inpatient environments, despite it being a relatively common phenomenon in such settings. Modestin and Kamm (1990) concluded that suicide attempts or deliberate self-harm (DSH) occurred much more frequently among psychiatric

inpatients than general hospital inpatients. The results of outcome studies of psychological interventions delivered in the community are not necessarily generalisable to inpatient settings due to differences between such environments. Inpatients tend to experience far more contact and interaction with healthcare professionals, including those delivering psychological interventions, than community clients receiving relatively brief amounts of time with professionals, for example through weekly therapy sessions. Therefore, intervention itself may stray outside the boundaries of group or individual therapy sessions in an inpatient context. Also, it may be clearer to define the impact of events and relationships with others on intervention outcome for inpatients than clients living in the community. Therefore, a review of studies specifically related to inpatient treatment can provide a clearer indication of the most beneficial modes of psychological intervention for use in the inpatient environment, bearing in mind the unique features of the context.

The aim of the current review is to provide a comprehensive and critical review of available outcome data regarding psychological interventions specifically or partially aimed at reducing DSH in mental health inpatient settings. Firstly, an overview of previous reviews will be presented, followed by a critical review of specific outcome literature for interventions addressing DSH in inpatient settings. Clinical implications of outcome study findings will be presented, and directions for future research suggested.

1.2.2 Definitions

It is difficult to ascertain whether research is looking at DSH due to the variety of terms used to describe behaviours that involve an individual inflicting self-injury, including 'self-harm', 'self-injurious behaviour', and 'self-mutilation'. The term 'parasuicide' is also used to refer to any act of self-harm with or without suicidal intent. Therefore, it can be unclear in studies referring to parasuicidal behaviour whether individuals experienced suicidal intent when displaying self-injurious acts. Modestin and Kamm (1990) cited parasuicide as a predictor of future suicidal behaviour and completed suicide, and stated that:

...it is not possible to differentiate reliably between suicide attempts in the narrow sense (death intended) and parasuicide (death not intended)... (Modestin and Kamm, 1990, p. 225).

Jackson (2000) stated that deciding whether a case constitutes DSH is always subjective to some extent.

1.2.3 Borderline Personality Disorder and deliberate self-harm

DSH is commonly linked with personality disorders, particularly Borderline Personality Disorder (BPD). Included in the diagnostic criteria for BPD defined by the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV (APA, 1994) are:

...recurrent suicidal behaviour, gestures or threats, or self-mutilating behaviour. (APA, 1994, p. 673).

The International Classification of Diseases, ICD-10 (WHO, 1992) describes a borderline subtype of Emotionally Unstable (Borderline) Personality Disorders, and included in the criteria is a:

“liability to become involved in intense and unstable relationships”
that could be associated with “suicidal threats or acts of self-harm.”
(WHO, 1992, p. 205).

Sansone, Songer, and Gaither (2001) found evidence to support a strong association between DSH and the diagnosis of BPD in mental health inpatients.

One estimate suggested that BPD occurs in up to 15-20% of all psychiatric inpatient populations (for example, Oldham, 2006). Söderberg (2001) assessed the prevalence of personality disorders in inpatients with a history of parasuicide. Of the 64 patients included in the study, 78% met DSM-IV (APA, 1994) criteria for a personality disorder, and the majority (55%) met the criteria for BPD. Historically, personality disorders have been viewed as stable with questionable treatability, but this view is increasingly being challenged (for example, Adshead, 2001; Gabbard, 2000). Oldham (2006) discussed recent research suggesting that BPD is variable over time, and that individuals who initially met BPD criteria can experience “remission” of meeting no more than two criteria.

1.2.4 Dialectical Behaviour Therapy

Many of the research articles presented in this review have evaluated the use of Dialectical Behaviour Therapy (DBT), which was developed by Linehan (Linehan, Armstrong, Suarez, Allmon, and Heard, 1991; Linehan 1993a) as cognitive-behaviour therapy specifically aimed at individuals presenting with BPD. It follows biosocial theory, positing that the central difficulties in BPD are emotional dysregulation, and invalidation of the individual’s behaviour and reported thoughts and feelings from the environment. The client and therapist agree on therapeutic

goals that include a progression towards change, flexibility, and acceptance. Key areas are core mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance (Linehan, 1993b). Swenson, Sanderson, Dulit, and Linehan (2001) suggested that the inpatient environment is not wholly conducive to carrying out DBT, largely due to the power differential between staff and patients, which works against the idea of a collaborative therapeutic relationship. Also, emotional triggers tend to be at a high level, making it difficult for new behaviours to be learnt, and there is the additional need for new behaviours acquired in the context of the inpatient unit to be generalised to life in the community. Robins and Chapman (2004) stated that the majority of literature evaluating DBT has focused on the initial stage of the intervention, which includes attempting to stop DSH.

Linehan et al. (1991) conducted one of the earliest outcome studies of DBT, comparing hospital readmissions in community participants during a one-year DBT intervention with clients receiving alternative therapy referrals. A reduction in parasuicide was found in both groups, but the reduction was more significant in the DBT group. The control group experienced significantly more days in a mental health inpatient setting than the DBT group, and tended to have a higher number of admissions per person. However, there were no significant differences in the likelihood of at least one hospital admission during the year. The DBT intervention did not prevent one patient from committing suicide.

Linehan et al. (2006), again with community participants, found no significant differences in DSH incidence or frequency between patients who received one year's DBT and those who received one year of non-behavioural psychotherapy.

However, the DBT condition was superior in preventing suicide attempts, reducing the need for general hospital and inpatient care, and had much lower dropout rates than the comparison condition. The DBT patients were also less likely to continue psychiatric medication during treatment. Linehan et al. (2006) concluded that research needs to draw more light upon which components of DBT are particularly effective, although they did suggest that delivering individual and group DBT concurrently may contribute to its efficacy.

1.3 Method

1.3.1 Search strategies

Automated searching was carried out using PsycINFO, Academic Search Premier, Medline, Proquest, and SCOPUS databases, using and combining the following terms: “deliberate self-harm”, “self-harm”, “parasuicide”, “treatment”, “intervention”, “therapy”, “inpatient”, “Borderline Personality Disorder”, “BPD”, and “hospital”. A search of the Cochrane Library was conducted (Higgins and Green, 2008), which yielded two results of relevant previous literature reviews. Further literature was found from searching references of articles discovered through automated searching. Advice on relevant articles was also sought from the academic and clinical supervisors for the author’s doctoral thesis. Using these methods, ten relevant previous reviews were identified and are summarised in this review, and 22 articles evaluating the outcome of interventions were identified for inclusion.

1.3.2 Studies included and excluded in the review

Studies clearly evaluating the results of interventions for self-harming behaviour, often as part of a BPD presentation, in relation to inpatient settings, were evaluated in this review. There are a few studies that were included that refer to the impact of interventions upon suicidal behaviour rather than DSH, as this term has appeared to include self-harming behaviour with or without suicidal intent, similarly to articles referring to parasuicide. Studies in which patient status was unclear were excluded from the review. Some studies have not measured DSH as an outcome, but have made conclusions regarding the effect of interventions used upon DSH, and therefore were considered relevant for inclusion. Research looking at reports of the subjective helpfulness of interventions has also been included. Kazdin (1999) discussed the importance of considering clients' perceptions of interventions since measures of symptom change may only reflect the clinician's perspective. Finally, studies evaluating interventions that have involved partial hospitalization, or that have not been carried out in an inpatient setting but have compared mental health inpatient admissions, have been included, as they have provided information regarding the need for inpatient interventions.

1.4 Previous Reviews

Conclusions from previous reviews on interventions for DSH and BPD will be summarised to establish the current understanding of what is likely to be helpful in treating self-harm in mental health inpatient environments, and highlighting gaps in existing literature. No previous reviews have concentrated solely on interventions for DSH in inpatient settings, but have included brief summaries of conclusions from inpatient interventions.

1.4.1 Reviews on the effectiveness of interventions for DSH

Five recent reviews on research literature for DSH interventions are discussed and summarised in Table 1.1.

Hepp, Wittman, Schnyder, and Michel (2004) cited three relevant studies, one of which concluded that ten-day structured inpatient treatment might be beneficial, without making any clear conclusions about effective modes of intervention. Some support was given for psychodynamic therapy involving partial hospitalization over 18 months, which proved effective in reducing DSH and suicide attempts during the course of treatment, and at 18 months post-treatment. It was suggested that the success of partial hospitalization could be partially attributable to clients being contacted and pursued if they failed to participate or attend any elements of therapy. Hepp et al. (2004) highlighted the importance of the therapist establishing a “trustful relationship” with the client for increasing intervention effectiveness. Fortune and Hawton (2005) provided a research update regarding DSH in children and adolescents, and cited a study comparing DBT and a psychodynamically oriented intervention, the former resulting in fewer behavioural incidents. Hawton et al. (1999) conducted what is perhaps the most in-depth review of randomised controlled trials (RCTs) of the psychosocial and physical treatment of DSH. An earlier review covering fewer studies (Hawton et al., 1998) provided identical conclusions. Only one study included involved inpatient treatment, which compared behavioural therapy with insight-oriented therapy, and it was considered that no meaningful conclusions could be made due to a small participant group.

Townsend et al. (2001) conducted a meta-analysis of six trials looking at the efficacy of problem-solving interventions following DSH. Significant reductions in negative mood scores following problem-solving treatments indicated that more patients who received problem-solving intervention improved compared to control interventions. From this review, no conclusions could be made regarding whether reported changes would mediate reduction in DSH repetition, but the results were comparable to previous results found in conjunction with reductions in DSH. There were variations in whether participants were DSH repeaters across the studies reviewed, the content and context of problem-solving therapy varied across trials, and data regarding mood was inadequately reported in some trials.

Hepp et al. (2004) stated a need for further research regarding DSH interventions, although specific areas were not highlighted. Arensman et al. (2001) focused on how each trial reviewed had been conducted, which raised some important methodological considerations, but was less helpful in drawing clear conclusions about effective interventions. They stated that comparison amongst trials was difficult due to intervention diversity and the wide range of outcome measures used. Arensman et al. (2001) and Hawton et al. (1998; 1999) reported a need for larger sample sizes in evaluative studies in order to be able to obtain clinically significant results. Hawton et al. (1998; 1999) simultaneously suggested that research in specific subgroups of self-harmers, which would yield smaller sample sizes, was also needed. They also concluded that there have been too few trials considering the extent of DSH in young people. Arensman et al. (2001) also called for more detail to be included on intervention, randomisation, and participant population, and called for standard outcome measures to be utilised. Fortune and Hawton (2005)

emphasised the importance of investigating barriers to help-seeking in young people, especially in high risk groups and males, so that intervention becomes tailored to maximise outcome effectiveness. Hawton et al. (1999) discussed how the majority of outcome studies have excluded clients who required mental health inpatient care, despite the fact that a large proportion of clients presenting to general hospitals following DSH require such treatment.

Table 1.1: Previous Reviews of Interventions for Deliberate Self-Harm

Authors	Year	Reviewing...	Conclusions
Hepp, Wittmann, Schnyder & Michel	2004	25 RCTs evaluating outcome of psychological & psychosocial interventions after attempted suicide & DSH	Short hospital admission for patients without immediate treatment needs showed no benefit. ST inpatient treatment with structured therapy may be beneficial, although unclear what treatment useful. Some support for psychodynamic therapy involving partial hospitalization. Importance of therapeutic alliance emphasised. Need for further research in intervention following DSH.
Arensman et al.	2001	20 RCTs of psychosocial & pharmacological treatment following DSH	Comparison among trials difficult due to intervention diversity & wide range of outcome measures. Larger sample sizes needed. Further trials of specific subgroups of self-harmers needed. More detail on intervention given needed. More information on randomization & patient population needed. Standard outcome measures should be used.
Fortune & Hawton	2005	DSH in children & adolescents (including treatment & service issues)	Evaluations of CBT only recently included DSH as outcome in young people. Inpatient DBT was more beneficial than inpatient psychodynamic intervention. Importance of investigating barriers to help-seeking emphasised. Possible external influences important to consider in research.
Hawton et al.	1999 (1998)	23 RCTs of psychosocial & physical treatment vs. any controls in treatment of DSH	Insufficient evidence to make firm recommendations about effective forms of treatment. Too few subjects to detect clinically meaningful differences in rates of DSH between treatments. Most participants recruited following general hospital admission, mostly outpatient treatment; clients requiring inpatient treatment excluded. Few trials on adolescents. Not always same method of DSH in participants, sometimes method not specified. Need for large trials of intervention shown in small trials. May be beneficial for studies to look at outcome variables other than DSH.
Townsend et al.	2001	Meta-analysis of 6 trials assessing efficacy of problem-solving interventions following DSH, measuring depression, hopelessness, and improvement in problems as outcomes.	No conclusions could be made with regard to helpfulness in reducing DSH. Variations DSH, & in content & context of problem-solving intervention across studies. Confirmation of findings in large trial desirable.

1.4.2 Reviews on the effectiveness of interventions for BPD

Previous reviews of interventions for inpatients with a diagnosis of BPD are summarised in Table 1.2.

Robins and Chapman (2004) cited three studies evaluating the use of DBT inpatient programmes, all of which provided results suggesting DBT was effective in reducing parasuicidal behaviours. Binks et al. (2007) reviewed one study (Bateman and Fonagy, 1999) that found that clients who attended a psychoanalytic oriented day hospital treatment were less likely to be admitted to inpatient care, or re-admitted to general hospital, than clients in general psychiatric care. Koerner and Linehan (2000) reviewed three studies evaluating DBT adapted for inpatient settings, and discussed two studies reporting the use of DBT in forensic and criminal justice settings. Positive outcomes, including reductions in parasuicide, were reported in two of the studies evaluated. Chiesa (2005) reviewed varied inpatient psychosocial interventions for BPD, and concluded that there was a considerable amount of improvement in patients following intervention. Springer and Silk (1996) discussed how group therapy for BPD can be applied in cases of short-term mental health inpatient hospitalization. Psychoanalytic group therapy had not proved helpful in the context of brief hospitalization, and even resulted in some deterioration in patients' presentations. Groups focusing on interpersonal interactions and self-expression had been shown to be more beneficial in short-term and long-term stays. A reduction in parasuicidal behaviours following DBT inpatient groups was reported.

Springer and Silk (1996) also focused on patients' perceptions of therapy. Patients with personality disorder diagnoses reported valuing group therapy more than individual therapy, and more so than other patients. Patients found the "compassionate and practical approach" helpful, and felt that they would be able to utilise skills learnt in groups once back in the community. Robins and Chapman (2004) only provided an overview of DBT effectiveness in different patient subgroups. Binks et al. (2007) point out that positive results require replication on a larger scale and in different settings, and stress the importance of further longitudinal trials as they demonstrate the clinical effectiveness and cost-effectiveness of interventions. In addition, Koerner and Linehan (2000) sought further investigations of DBT adaptations in inpatient and forensic settings. Demonstrating caution when adapting DBT for inpatient group interventions was suggested due to the potential for "acting out" behaviour, including DSH, following discussion of parasuicidal behaviour within group sessions. Chiesa (2005) also reported how the inpatient environment could have a detrimental effect for patients with BPD presentations, suggesting that a continual therapeutic environment may be emotionally unbearable for clients.

Chiesa (2005) suggested that observational and naturalistic studies do not overestimate the treatment effects of the condition under evaluation compared to RCTs. However, naturalistic studies cannot confirm which aspects of intervention can account for outcome. Medication effects have been a confounding variable in inpatient studies. Some evaluations cited have suggested that shorter hospital stays followed by ongoing intervention and support in the community, and partial hospitalization, were more effective for patients displaying BPD than long-term

inpatient stays. Springer and Silk (1996) provided a contrasting argument to Hepp et al. (2004) in their criticism of DBT groups for not emphasising group process and relying on the positive therapeutic alliance, which could contribute towards patient compliance rather than lasting change. This review recommended further research evaluating groups adapted for short-term inpatient settings as mental health inpatient stays have gradually decreased. The generalisability of findings from older studies to current inpatient environments was questioned due to changes in average patient presentations and the shortening of average hospital stays.

1.4.3 Conclusion from previous reviews

Previous reviews have provided limited information on the effectiveness of interventions for inpatients who display DSH, but have shown some support for psychodynamic therapies and DBT in helping to reduce self-harm. Support has been given for partial hospitalization and short-term inpatient interventions. The importance of listening to patients' perceptions of the intervention experience has been emphasised, although there have been some conflicting arguments regarding a focus upon the therapeutic alliance. Larger sample sizes have been called for as well as more research focusing on particular client groups. It has also been suggested that future research could include more detail, standard outcome measures, and consideration of barriers to help-seeking. Follow-up data have proved helpful in demonstrating long-lasting outcomes, and the meaningfulness of observational study results has been demonstrated.

Table 1.2: Previous Reviews of Interventions for Borderline Personality Disorder

Authors	Year	Reviewing...	Conclusions
Robins & Chapman	2004	Evaluations for DBT intervention programmes	DBT found to be effective in reducing parasuicidal behaviours in inpatients. No systematic data for partial hospitalization programmes using DBT. No detailed information on outcome data.
Binks et al.	2007	Review of psychological therapies for individuals with BPD.	Only one study reviewed inpatient intervention. Psychoanalytic oriented hospital treatment found to be effective compared to general psychiatric care. Results require replication on larger scale & more longitudinal data needed.
Koerner & Linehan	2000	DBT for patients with BPD diagnosis	Fewer DSH acts during or following DBT interventions. LT effectiveness studies, studies of efficacy where DBT adapted to different settings, & additional development of DBT with studies in the area, all needed. Caution required when adapting DBT for inpatient group interventions.
Chiesa	2005	Inpatient psychosocial interventions for BPD	Inpatient environment could have detrimental effect on BPD inpatients. Results from RCTs and naturalistic/observational studies comparable. However, naturalistic studies do not suggest whether inpatient environment in itself helpful or what elements of treatment effective. Medication effects are a confounding variable. ST inpatient stays with follow-up support may be more beneficial than LT hospitalization.
Springer & Silk	1996	Group therapy for BPD	Psychoanalytic group therapy not found to be effective for BPD, but DBT groups adapted for inpatient settings found to be helpful, including reduction in parasuicide. Patients with BPD reported valuing group therapy more than individual therapy, & more than other patients. Lack of emphasis on group process & reliance on positive therapeutic alliance may be detrimental to patients. Generalisability of results questioned. Further evaluations of groups in ST inpatient environments & use of post-discharge follow-up data needed.

1.5 Main Review

1.5.1 Intervention specifically aimed at reducing DSH with inpatient populations

Four studies evaluating the use of DBT in relation to inpatients with DSH, and two studies reporting on single cases, are reviewed here and summarised in Table 1.3.

Low, Jones, Duggan, MacLeod, and Power (2001) and Low, Jones, Duggan, Power, and MacLeod (2001) reported on the same intervention programme, which evaluated the outcome of a one-year DBT package with female inpatients meeting BPD diagnostic criteria. Low, Jones, Duggan, MacLeod, et al. (2001) focused on case studies of three participants who completed this intervention. DSH was reduced significantly in all three cases overall, although one patient displayed an increase in DSH after moving to a less secure ward. Two of the clients sought further ongoing therapy, indicating that they valued the intervention and felt the skills they attained through engaging in DBT helped them with their difficulties. Low, Jones, Duggan, Power, et al. (2001) evaluated the outcome data for ten patients who completed the full year of therapy and follow-up. All ten participants displayed a significant reduction in DSH between pre-treatment and the final follow-up period. Although there was a slight increase in DSH at the three-month follow-up interval, decreases were found at all other measurement points. These results do not reflect individual differences within the participant group, such as the deterioration in symptoms in one patient.

Three patients dropped out of the intervention described by Low, Jones, Duggan, Power, et al. (2001), two of whom were considered to display learning difficulties, and one due to high risk, which may suggest that DBT cannot easily be applied to clients in these groups. Low, Jones, Duggan, MacLeod, et al. (2001) speculated about whether one year's therapy might be insufficient for the extreme level of difficulties present in their participants. Low, Jones, Duggan, Power, et al. (2001) stated that it was impossible to demonstrate that DSH reduction was due to receiving DBT, although they posited that DSH is typically resistant to treatment and therefore spontaneous reduction due to nonspecific factors would not be expected.

Interventions other than DBT have also provided positive results in reducing DSH in inpatients. Wheatley and Hollin (2005), and Bloxham, Long, Alderman, and Hollin (1993) both presented single case studies of inpatients, both female and meeting BPD diagnostic criteria. Wheatley and Hollin (2005) demonstrated an immediate and substantial decrease in DSH, which was maintained at three months follow-up in a young woman who received a four-month behavioural coping skills intervention. It was acknowledged that behaviour changes could have been attributable to a revision of the patient's treatment goal from discharge to moving to a less secure unit, and concurrent ongoing therapy was an uncontrolled variable, although medication effects were controlled for. Bloxham et al. (1993) described two forms of behavioural treatment for a 35 year-old woman with a very complex presentation of DSH. The patient viewed her self-starvation as a form of DSH. Physical aggression and DSH virtually disappeared following intervention. The generalisability of these two cases is questionable as a result of being single case

studies, but the interventions outlined addressed the individual needs and difficulties of the patients being treated.

Summary

These studies have evaluated interventions employing cognitive and/or behavioural strategies, including DBT, as being largely effective in reducing DSH in inpatients. However, there has been some suggestion that standardised programmes fail to meet clients' individual needs. Some studies presented tailor-made interventions for individual clients and their findings may be less generalisable as a result, but they displayed outcomes suggesting they had been effective. The importance of a stable environment in improving DSH was highlighted by Low, Jones, Duggan, MacLeod, et al. (2001). Low, Jones, Duggan, Power, et al. (2001) discussed how methods of DSH varied across participants, so there were distinct individual differences in presentation despite similarities in diagnosis. Bloxham et al. (1993) stressed how eating disorders may serve a self-harming function in BPD patients.

Table 1.3: Studies Evaluating Interventions Specifically Aimed at Reducing DSH

Name	Year	Method	Participants	Intervention	Outcome
Low, Jones, Duggan, MacLeod, & Power	2001	Case studies from female BPD patients who self-harm & received DBT.	15 in DBT group, 3 case studies used, all female (25, 34 & 19 years old) with BPD diagnosis.	DBT group & individual strategies for each case.	Two patients showed decrease in DSH, one continued to fluctuate.
Low, Jones, Duggan, Power & MacLeod	2001	Female inpatients meeting BPD criteria given one-year package of DBT.	10 females (mean age 28.7 years) with BPD diagnosis, who completed intervention & follow-up measures.	One-year DBT package.	Significant reduction of DSH during therapy, maintained at 6-month follow-up.
Wheatley & Hollin	2005	Single-case A-B design – 23-day baseline phase, 4 month treatment phase, & 3 month follow-up phase.	One female adolescent inpatient (18 years 11 months at beginning of project) with BPD diagnosis.	Behavioural coping skills programme with cognitive & behavioural elements.	Immediate & substantial decrease in DSH during treatment phase, maintained at follow-up.
Bloxham, Long, Alderman & Hollin	1993	Single-case design of one patient, individual behavioural modification programme used.	One female inpatient (35 years old) with BPD diagnosis presenting with DSH, self-starvation & aggression.	Behavioural token economy programme to address DSH & aggression, & individual behavioural modification programme to address self-starvation.	DSH and physical aggression virtually disappeared, and upward trend of food and fluid intake during intervention phases.

1.5.2 BPD interventions, including measurement of DSH

Seven studies are reviewed that involve evaluations of inpatient intervention for BPD including DSH as an outcome measure, which are summarised in Table 1.4.

Bohus et al. (2000, 2004) reported on the same three-month DBT programme. All participants in both studies were female with a BPD diagnosis, and had displayed at least two recent parasuicidal acts. Bohus et al. (2000) demonstrated an overall reduction in DSH at four weeks post-discharge following the programme. However, DSH actually increased in four clients, one of which reported to have “learnt” cutting behaviour on their inpatient ward. The authors discussed how positive effects found could be attributed to spontaneous recovery, placebo expectancies, or other uncontrolled factors, such as hospital stay and staff attention, and therefore called for a randomised study comparing different treatment modalities of inpatient intervention, which Bohus et al. (2004) went on to conduct. DBT was found to be more effective than a naturalistic waiting list condition in which participants received some form of professional mental health care. More DBT patients abstained from DSH at post-treatment follow-up. It is possible that individuals who would not have benefited from DBT dropped out differentially. The authors highlighted the importance of comparing inpatient treatment with outpatient treatment as well as other inpatient programmes.

Barley et al. (1993) made comparisons in DSH levels before and after the introduction of a DBT milieu. Parasuicide was significantly lower following the introduction of DBT, but there were no significant differences in time periods between parasuicidal acts between the experimental group and a comparison group of patients on a ward where DBT had not been introduced. Describing the development of the DBT programme was the focus of this article rather than outcome evaluation, and no longitudinal follow-up data was presented.

Springer, Lohr, Buchiel, and Silk (1996) evaluated the modification of DBT for a two-week inpatient intervention with male and female patients with personality disorder diagnoses. Patients either received DBT skills training through a 10-session Creative Coping, CC, group or a Wellness and Lifestyle, W & L, discussion group. Two participants from the CC group started self-harming whilst engaged in the treatment, and three participants from this group threatened DSH or suicide close to discharge. It was suggested that discussing DSH could encourage it, and that it was possible that the CC group members verbalised their feelings more than the W & L group members. The CC group was valued by participants for its universality and the opportunity to discuss similarities in experiences and difficulties with others, whereas the W & L group members valued the importance of distraction that their group provided. The CC group members said they felt they would be able to use skills learnt in the group in the community following discharge. It was suggested that the length of stay (12.6 days on average) was not long enough to see differential treatment effects, and a common enjoyable experience may have been sufficient for a positive outcome. An additional comparison group may have helped to decide whether

brief hospitalization with any intervention was helpful, and using a unit where the groups were being introduced for the first time for all staff may have been beneficial. Post-discharge data would have been helpful.

Sachsse, Vogel, and Leichsenring (2006) described an intervention programme provided in two phases for females presenting with BPD, complex Post-Traumatic Stress Disorder, PTSD, DSH, and depression. Phase One involved a two-week inpatient admission for diagnostic studies and stabilisation, and patients were readmitted 7.5 months later for Phase Two, involving trauma-focused intervention including Eye Movement Desensitization and Reprocessing, EMDR, and stabilising psychodynamic treatment. Thirty of the patients who experienced this intervention completed one-year follow-up interviews. DSH stopped in the majority of participants following Phase Two. No significant improvements were found in patients receiving Treatment As Usual or trauma-specific treatment during the waiting time between phases. All participants did require some subsequent inpatient treatment, but this was 0 - 4 days in all but two participants during the first year after treatment. Only approximately 20% of the original participant sample provided follow-up information and these patients may have improved differentially more than those who refused to complete follow-up assessments. The authors highlighted the need for a stable environment for EMDR and trauma exposure that many units providing acute mental health care may not be able to provide.

Hoch, O'Reilly, and Carscadden (2006) evaluated the first implementation of Relationship Management Therapy, RMT, in a psychiatric inpatient setting,

which involved patients choosing their own treatment, which was limited by resources and availability. A key component of the therapy is that patients are discharged for 24 hours following any threats of, or actual, DSH or aggression. DSH reduced significantly from an average of 2 ± 3 incidents per year per patient to none during treatment. The authors suggested that RMT was a cost-effective treatment as it did not result in a significant increase in hospital admissions, although there was a slight increase, and inpatient days declined considerably. The authors did acknowledge that participants remained disturbed if they were discharged for 24 hours, which may have resulted in community mental health agencies or the Police becoming involved if any incidents occurred.

Clarkin et al. (2001) looked at hospitalization rates in outpatients who received one year of Transference Focused Psychotherapy, TFP, a psychodynamic treatment specially modified for people with BPD, including a focus on the containment of self-injurious behaviours. DSH frequency did not decrease. There was a significant reduction in suicide attempts, fewer hospitalizations, and fewer inpatient days during the intervention. However, not all positive results were maintained after treatment. There was no comparison group and no follow-up data for this study. Giesen-Bloo et al. (2006) carried out an outcome study of TFP for BPD with a comparison group of schema-focused therapy, SFT, with community clients. DSH was not discussed as a specific outcome, but both conditions were considered to have brought about significant change in terms of BPD symptoms and dysfunction, although SFT was found to be the superior mode of therapy. Such a comparison with BPD inpatients, measuring

DSH as a specific outcome, would help to provide some further indications as to the effectiveness of TFP (and SFT).

Summary

The implementation of DBT programmes with community clients diagnosed with BPD has led to reduced levels of DSH and hospital readmissions. With inpatient populations, DBT has shown effective results in reducing DSH when administered to patients for at least three months. Short-term DBT groups provided with brief hospitalization have not effectively helped to reduce DSH, where a general discussion group actually proved more beneficial. Structured trauma-focused inpatient intervention and Relationship Management Therapy have both been shown to help reduce DSH. Transference Focused Psychotherapy for community clients has provided mixed outcomes, although some positive results have been found, along with positive outcomes for Schema-Focused Therapy.

Table 1.4: Studies Evaluating BPD Interventions, Including Measurement of DSH

Name	Year	Method	Participants	Intervention	Outcome
Bohus et al.	2004	Compared DBT inpatient treatment with naturalistic waiting list. Participants randomly allocated to condition.	All female, met BPD criteria, & displayed one suicide attempt or a minimum of 2 recent self-injurious acts. Final sample contained 31 who completed DBT group & 19 waiting list clients (DBT mean age 29.1 years, waiting list mean age 29.5 years).	Treatment group received 3-month DBT inpatient programme. Waiting list participants received some form of professional mental health care.	12 of the 19 waiting list clients hospitalized at least once. Significantly more DBT patients abstained from DSH post-treatment.
Bohus et al.	2000	Tested feasibility, safety & effectiveness of 3-month inpatient DBT module with pre- and post-comparison of treatment outcomes.	24 female patients treated in 1996 & 1997 as inpatients. All had BPD diagnosis, & had carried out at least 2 parasuicidal acts &/or one suicide attempt in previous two years. Mean age 28.5 years, with average of 3.9 hospital stays.	Participants spent an average total of 94 days on the ward & received 3-month DBT programme.	Overall decrease in DSH after discharge, but increased in 4 clients.
Barley et al.	1993	Modified psychodynamic treatment programme for BPD inpatients on 16-bed unit, & gradually introduced DBT elements.	During study, 130 patients discharged from the Personality Disorder Treatment Programme where patients received interventions, median age 30 years, 79% female, median inpatient stay 106 days.	DBT skills training group, DBT milieu, homework groups, behavioural analysis & problem-solving of parasuicidal behaviours. Intervention lasted length of inpatient stay.	There were no significant differences between time periods on parasuicide for patients on ward not receiving DBT, but parasuicide was significantly lower after the introduction of DBT.
Springer, Lohr, Buchiel & Silk	1996	Examined modification of DBT for ST inpatient treatment with average stay of less than 2 weeks. Compared DBT group with general discussion group.	31 participants, 16 allocated to the CC group & 15 allocated to W & L group (21 female, 10 male, mean age 31.4 years). 13 participants met criteria for BPD & rest of group met other PD characteristics.	Patients placed in either 10-session Creative Coping (CC) group or Wellness and Lifestyle group (W & L, control group).	CC group acted out significantly more. 3 participants from CC group threatened DSH or suicide close to discharge. No increase in DSH shown in W & L group. BPD patient outcome no different to rest of group.

Table 1.4 (continued): Studies Evaluating BPD Interventions, Including Measurement of DSH

Name	Year	Method	Participants	Intervention	Outcome
Sachsse, Vogel & Leichsenring	2006	Described 2 phases of inpatient treatment given to groups of patients between 1996 and 2000.	All female, presenting with BPD, complex PTSD, DSH, & depression. Initial patient sample was 153 (mean age 32.4 years), & 30 patients in follow-up group. Before the study participants were self-harming up to 7 times a month, & all had previously received outpatient or inpatient TAU.	Phase 1 - 2-week admission for diagnostic studies & stabilisation. Patients then discharged & readmitted 7.5 months later for Phase 2 - trauma-focussed inpatient treatment including EMDR & stabilising psychodynamic treatment. Follow-up group received average of at least 87.10 days inpatient psychotherapy.	DSH virtually stopped in all participants. Phase 1 not considered effective short-term psychotherapy programme in itself, but Phase 2 was effective. No significant improvements shown in those receiving TAU or trauma-specific treatment during waiting time.
Hoch, O'Reilly & Carscadden	2006	Evaluated first implementation of Relationship Management Therapy (RMT) in a psychiatric inpatient setting between 1998 and 2000.	27 patients admitted to programme (25 female, 2 male, mean age 38 years). All participants met DSM-IV BPD criteria, & presented with high level of comorbid conditions.	In RMT patients chose their own treatment. Patients discharged for 24 hours following any threats of or actual DSH or aggression.	DSH reduced significantly from average of 2±3 incidents per year per patient to none during treatment. There was a nonsignificant increase in hospital admissions, although number of inpatient days declined.
Clarkin et al.	2001	Looked at hospitalization rates in outpatients following Transference Focused Psychotherapy (TFP).	17 people were in the treatment group (mean age 32.7 years), all female, with at least one Axis I diagnosis and one Axis II diagnosis.	One-year psychodynamic treatment specially modified for people with BPD, focussing on containment of suicidal & self-harming behaviours.	DSH did not decrease. Significant reduction in suicide attempts during intervention. Not all positive results maintained after treatment completion. Fewer hospitalizations & fewer inpatient days during treatment.
Giesen-Bloo et al.	2006	Compared TFP for BPD with a comparison group of schema-focused therapy (SFT), with community clients.	Outcomes for 86 community patients meeting DSM-IV BPD criteria analysed (42 received TFP, 44 received SFT).	Three-year intervention of TFP or SFT experienced.	DSH was not discussed as a specific outcome, but both conditions were considered to have brought about significant change in BPD symptoms and dysfunction, although SFT was found to be the superior mode of therapy.

1.5.3 BPD studies not measuring DSH as outcome

Two studies evaluating inpatient intervention for individuals meeting BPD criteria, not measuring DSH as an outcome, are discussed and summarised in Table 1.5. Positive results on other outcome measures could suggest positive outcomes regarding DSH levels.

Kröger et al. (2006) stated that their research included participants with more complex presentations than previously included in evaluation data, but did not measure DSH levels. Other psychopathology was considered to be significantly reduced at post-treatment and follow-up, although pathological levels of symptoms were still present in one individual with a BPD presentation. This information does not provide any clear indications about the effects that the intervention had on DSH. A control group was not included in this study, and interviewers were not blind to the treatment received by participants. Silk et al. (1994) did not report on DSH levels following a short-term time-limited intervention carried out on a general mental health inpatient unit, although it could be a specific goal for patients. Like Springer et al. (1996), a Creative Coping, CC, group was delivered, as well as behavioural treatment contracts defining achievable goals, and a discharge date was named as soon after admission as possible. Outcome evidence was largely anecdotal, with no standardised outcome measures reported. The CC group participants reported that topics were related to personal concerns, that the group was an important part of their hospitalization, and that it was more beneficial than groups previously attended. There was a significant effect showing that patients who attended the CC group were more likely to use lessons learned in the group in the future to help them cope with their difficulties, similarly to Springer et al's (1996) results.

Summary

Both of these studies concluded that positive outcomes resulted from incorporating DBT in inpatient settings with patients considered to display characteristics of BPD. As the intervention aimed at addressing mental health and emotional difficulties usually displayed by this patient group, it is difficult to understand why DSH or parasuicidal behaviour, or the risk of its occurrence, were not amongst outcomes measured.

Table 1.5: BPD Studies Not Measuring DSH as an Outcome

Name	Year	Method	Participants	Intervention	Outcome
Kröger et al.	2006	Aimed to evaluate effectiveness of DBT in more severe and broader disturbed sample of BPD individuals, with high level of comorbidity.	Participants were inpatients in unit between 2000 and 2001, comprising 6 men and 44 women, with mean age of 30.5 years, with a mixture of demographic variables.	Three-month inpatient DBT programme, including individual therapy, problem-oriented techniques & group therapy. At 15-month follow-up 29 out of 37 participants were receiving outpatient psychotherapy, mostly CBT or insight-oriented therapy, and 15 were readmitted to inpatient care.	Psychopathology significantly reduced at post-treatment & follow-up. However, individual displaying BPD presentation who received DBT continued to suffer from pathological levels of symptoms.
Silk et al.	1994	Evaluated ST time-limited inpatient treatment in general mental health inpatient unit.	All participants had diagnosis of BPD. No detailed demographic information provided.	Programme included preadmission contracts, inpatient behavioural treatment contracts defining achievable goals, setting discharge as soon as possible, goal-oriented criteria for readmission, & focus on reduction of symptoms specific to current crisis. 10-session rolling Creative Coping (CC) group included in programme.	Evidence of effectiveness measured through patients' perceptions of improvement at discharge and at six-month post-discharge. Patients who attended the CC group reported finding the group helpful. There was a significant effect showing that patients who attended the CC group were more likely to use lessons learnt in the group in the future.

1.5.4 Suicide attempters

Four studies evaluating inpatient intervention for previous or current suicidality are discussed here and summarised in Table 1.6.

Van der Sande et al. (1997) examined the effectiveness of a crisis intervention approach for suicide attempters aged 15 years and over, combining brief inpatient treatment with subsequent 24-hour emergency access to the unit, problem-solving outpatient treatment, and home visits. The treatment did not reduce repeated suicide attempts. The outcome may have been biased by home visit research interviews, as the visits themselves may have been therapeutic. It was suggested that too broad an approach was used, with only a brief inpatient stay of one to four days.

Patsiokas and Clum (1985) did not use suicide attempting as a dependent measure because they felt attempts were so infrequent and rarely known to clinicians as a guide to the effectiveness of treatment. If improvement in correlated variables was shown, then it was considered possible that suicidal potential was also reduced. Participants were admitted to an inpatient unit following suicide attempts. They received one of three interventions: cognitive restructuring, problem-solving, and a control condition involving nondirective discussion sessions. There were no significant differences in self-monitoring of suicidal thoughts across the groups, but a significant drop in suicidal ideation could not be shown as initial levels were low. Monitoring ideation itself may have produced behavioural changes, although patients' expectations for this were checked. Also, for some patients, discharge was decided upon

due to the level suicidal ideation, which may have affected what was reported. The authors concluded that a problem-solving approach would be likely to reduce further suicide attempts because it reduced hopelessness and enhanced problem-solving skills in relation to suicidal thoughts.

Liberman and Eckman (1981) compared behaviour therapy with insight-oriented psychotherapy in inpatients who had made suicide attempts. Social skills training with anxiety management techniques were included in the behaviour therapy group. There was a significant reduction in suicide attempts following treatment in both groups. There was some blurring of the conditions because all participants experienced the same milieu and mixed on the unit, and there was overlap in the aftercare they received. Interview results suggested that the majority of participants displayed social skills deficits and chronically impulsive ways of responding to anxiety and stressors. It was suggested that training, family involvement and assertive aftercare are necessary with these presentations.

1.5.5 Suicidal adolescents

Katz, Cox, Gunasekara, and Miller (2004) specifically measured parasuicidal behaviour in their evaluation of the use of a two-week DBT intervention in an inpatient unit with suicidal adolescents. Comparisons were made with a second unit using traditional psychodynamically-oriented crisis assessment and treatment. Both groups demonstrated a reduction in parasuicide one year after discharge. The DBT patients had significantly fewer incidents on the ward than the comparison group. No completed suicides were demonstrated in

either group at one-year follow-up. Possible positive factors of the intervention were staff compassion and motivation in working with patients. The DBT patients mostly completed the whole course of therapy, and the intervention did not appear to foster a contagion effect of behavioural incidents on the ward. A medium effect size for inpatient treatment on future parasuicidal behaviour was found, but replication was sought due to the small participant group.

Summary

Short-term inpatient crisis intervention was not shown to be helpful in reducing suicide attempts, including DSH. Problem-solving intervention has been found to be more effective than cognitive restructuring or open discussion groups in improving symptoms related to suicide attempts, and a behavioural intervention including social skills training was shown to be more effective than insight-oriented psychotherapy in reducing suicidal behaviour. Short-term DBT with suicidal adolescents was shown to be more effective in reducing parasuicide incidents during the intervention, although patients receiving either this or a psychodynamic intervention displayed equally positive results at one-year follow-up.

Table 1.6: Studies Evaluating Inpatient Intervention for Suicidal Participants/Suicide Attempters

Name	Year	Method	Participants	Intervention	Outcome
Van der Sande et al.	1997	Compared effectiveness of crisis intervention approach for suicide attempters & TAU. Follow-up assessments carried out at discharge, & at 3, 6, and 12 months post-discharge.	All participants were 15 years + and received physical treatment 1993-1995 after suicide attempt. Participants were allocated randomly to experimental treatment group or TAU. 127 experimental participants and 134 TAU participants.	Treatment was 1-4 days inpatient stay with supportive milieu. Weekly appointments with CPN post-discharge. TAU involved assignment by routine clinical service.	Treatment did not reduce repeated suicide attempts.
Patsiokas & Clum	1985	Looked at correlated variables to suicide attempts & compared them as outcome across 3 therapy conditions in participants who had attempted suicide.	15 inpatients in a psychiatric unit admitted following suicide attempts. There were 5 participants in each treatment group.	Two treatment groups involved cognitive restructuring and problem-solving respectively. Control group involved nondirective discussion sessions.	No significant differences in self-monitoring of suicidal thoughts across groups. All groups showed a reduction in suicidal intent.
Liberman & Eckman	1981	Compared behaviour therapy with insight-oriented psychotherapy in inpatients who had made suicide attempts.	8 men & 16 women aged 18-47 years, referred to a 10-day inpatient programme following suicide attempts. All participants had made at least one previous suicide attempt in the previous two years, & considered all would meet criteria for at least one PD. Both groups experienced the same behavioural milieu & all received community aftercare post-discharge.	Behavioural therapy & insight-oriented therapy.	Significantly more improvement in behavioural treatment group in suicide attempts & ideation, sustained throughout 9-month follow-up period.
Katz, Cox, Gunasekara & Miller	2004	Comparing outcome with 2 groups of adolescents receiving different inpatient interventions.	62 adolescent inpatient participants, 52 girls & 10 boys (mean age 15.4 years). All had displayed suicide attempts or suicidal ideation severe enough to warrant inpatient admission. Outcome data available for 26 participants who received DBT & 27 control group participants.	Two-week adaptation of DBT inpatient programme compared with control group using traditional psychodynamic treatment programme.	DBT patients had significantly fewer incidents on ward than control group. Both groups demonstrated reduction in parasuicide one year post-discharge.

1.5.6 Partial hospitalization

Studies evaluating partial hospitalization have previously been included in reviews of self-harm interventions, and provided information on an alternative treatment option to complete inpatient intervention. Two studies have provided results suggesting that this intervention can effectively reduce DSH in men and women meeting BPD diagnosis criteria, and are summarised in Table 1.7. Bateman and Fonagy (1999) assigned patients to either partial hospitalization with long-term psychoanalytically oriented treatment for up to 18 months, or to a general psychiatric service control condition. Partial hospitalization included group analytic psychotherapy, and individual psychoanalytic psychotherapy, expressive therapy, and community meetings. The control group received regular psychiatric reviews when necessary, inpatient admission as appropriate, and community follow-up. DSH significantly decreased over the treatment course in the partial hospitalization group but not in the control group. The number of patients no longer self-harming after 18 months of treatment was significantly greater following partial hospitalization. There was also a significant reduction in suicide attempts in the treatment group after 18 months treatment, compared to a nonsignificant trend in the control group. The average length of inpatient stay increased overall in the control group but remained stable in the treatment group, in which there was only a reduction in the last six months of treatment, indicating a need for longer term intervention. A lack of ongoing treatment monitoring meant that there was a lack of clarity as to what therapeutic factors were beyond the use of a structured programme.

Bateman and Fonagy (2001) offered a follow-up programme to those who had received the intervention outlined above, and it was attended by 75% of the original participants. It involved group analytic therapy lasting 18 months and reviews in a psychiatric outpatient clinic if requested. The original control group continued to be reviewed by a psychiatrist and hospitalized if necessary. Twenty of the 22 treatment group participants did not display DSH two years after the beginning of the original study compared to 7 out of 16 in the control group, and there was a highly significant effect showing more controls self-harmed during the 18-month follow-up period. There continued to be fewer suicide attempts and hospitalizations in the treatment group. Medication effects were considered possible in both groups, but the partial hospitalization group gave fewer indications they would still benefit from medication, and showed a reduction in symptoms alongside a general medication reduction. There was no integrity measure used in the study, and differences found may have been due to staff experience and enthusiasm differences.

Summary

These results suggested that a less structured or intensive programme would be ineffective in comparison to a psychodynamic partial hospitalization intervention in lessening DSH and suicide attempts. However, Bateman and Fonagy (2001) concluded that further research needed to be conducted to clarify whether partial hospitalization was more effective than specialist outpatient treatment delivering similar packages to individuals with severe BPD.

Table 1.7: Studies Evaluating Partial Hospitalization

Name	Year	Method	Participants	Intervention	Outcome
Bateman & Fonagy	1999	Comparison of partial hospitalization using LT psychoanalytically oriented treatment for up to 18 months with general psychiatric service (control group).	Patients were referred to study if they met criteria for BPD. There was data for 19 patients in each group.	Experimental intervention included group analytic psychotherapy, & individual psychoanalytic psychotherapy, expressive therapy & community meetings. The control group received regular psychiatric reviews, inpatient admission as appropriate, & community follow-up.	DSH significantly decreased for the treatment group but not controls. Number of patients no longer self-harming after 18 months of treatment significantly greater in treatment group. Significant reduction in suicide attempts in treatment group after 18 months compared to nonsignificant trend in controls. Average length of inpatient stay increased overall in controls but remained stable in treatment group. Partial hospitalization treatment effective for both men and women.
Bateman & Fonagy	2001	Follow-up study to investigate maintained improvement following partial hospitalization intervention described in 1999 study, & whether further improvements occurred.	All of those in the treatment group from previous study included, including 3 who were not previously included (22 in total). Follow-up programme offered & received 75% attendance.	Follow-up programme involved twice weekly group analytic therapy lasting 18 months and review in psychiatric outpatient clinic if requested every 3 months. Original control group continued to be reviewed by psychiatry & hospitalized if necessary.	20 of the treatment group participants did not display DSH 24 months after beginning of original study compared to 7 in control group. Fewer suicide attempts & hospitalizations in treatment group than controls. Continued decline in symptom distress in treatment group, some decline in controls.

1.5.7 Patients' views of intervention

Two studies whose results have concentrated on presenting patients' views of the intervention are presented here, and summarised in Table 1.8.

Liebling and Chipchase (1996, 1999) reported on a feminist group intervention for female patients in secure mental health settings, and also described a case study following evaluation of the group. The group was initially established with five patients in a Special Hospital who were invited and chose to participate in the group, and selected the facilitators themselves through interview. The group sessions covered areas including reasons for DSH, positive and negative staff responses, guidelines for care plans for women who self-harm, common myths about DSH, and barriers to communicating distress. Educational information was also presented, and there were discussions and role-plays.

Semi-structured interviews of a pilot group revealed that participants viewed the group as a valued forum, and they felt exploring difficult issues in the group enabled them to make independent progress. Staff also valued the group and responded positively towards it. Psychometrics and cognitive-behavioural approaches were viewed as control, which is important to acknowledge when control can be viewed as a central issue in DSH. Liebling and Chipchase (1999) also made suggestions regarding changes that could be implemented, including the development of smaller units for women who self-harm, offering safety, containment and choice for patients, and emphasised the importance of gender-

sensitive service development. These articles did not discuss the limitations of the group intervention used or of the studies they conducted.

Summary

Neither of these articles discussed whether the group helped patients to reduce the level of seriousness or frequency of their DSH. It is not clear where all of the conclusions drawn in the studies came from in terms of the data collected. However, these qualitative studies did appear to provide in-depth information regarding patient experiences of intervention that many other studies have not considered. Interestingly, structured CBT interventions, used in many of the other studies cited in this review, were criticised by patients. The potential for organisational issues to conflict with the running of therapeutic groups was also raised.

Table 1.8: Studies Evaluating Patients' Views of Intervention

Name	Year	Method	Participants	Intervention	Outcome
Liebling & Chipchase	1999	Case study. Facilitators' discussions regarding proceedings of group sessions were recorded. Qualitative analysis including content analysis & grounded theory.	Five female inpatients with a DSH history living in a secure mental health setting (average age not given). Average length of stay at current unit at time of study was 8 years.	Feminist group intervention aimed at addressing DSH. Patients were heavily involved in development & evaluation of the group.	No outcome data provided on effect of intervention on level of DSH, although discussion of DSH & related topics considered beneficial. Patients reported valuing the group intervention, but did not like any use of psychometrics or structured cognitive-behavioural methods.
Liebling & Chipchase	1996	Initial evaluation of feminist group intervention for female inpatients relating to DSH experiences using qualitative methods.	Five female inpatients with a DSH history living in a secure mental health setting (average age not given).	Feminist group intervention aimed at addressing DSH. Patients were heavily involved in development & evaluation of the group.	No outcome data provided on effect of intervention on level of DSH. Patients reported valuing the group, but did not like any use of psychometrics or structured cognitive-behavioural methods.

1.6 Discussion

1.6.1 Discussion of studies reviewed

Of the 22 studies evaluated here, 9 have focused on the implementation of Dialectical Behaviour Therapy, DBT, and all demonstrated some positive changes in patients' symptoms. Reductions in levels of deliberate self-harm, DSH, were demonstrated in six studies, two have not measured DSH as an outcome, and DSH continued, and even worsened in some cases, in one study. It is important to point out that even in the DBT studies that showed positive outcomes overall, DSH was not necessarily reduced in every patient. Three studies reviewed used other cognitive-behavioural techniques, and all demonstrated positive changes, and DSH was reduced in the two studies that measured this outcome. Five studies have reported on outcomes following psychoanalytic or psychodynamic modes of intervention, some of which have used this form of therapy as control conditions. Three of the studies reported reductions in DSH in inpatients receiving such interventions. However, one study found that DSH did not decrease following Transference Focused Psychotherapy. Behavioural therapy, trauma-focused therapy, and Relationship Management Therapy were all reviewed in one study, and reported reductions in DSH. DSH was not reduced using a crisis intervention approach, which may predominantly be explained by the very short length of inpatient intervention. The implementation of a feminist group intervention was viewed positively by participants, and positive outcomes overall were suggested, although DSH frequencies were not measured. Non-directive discussion groups were used as control conditions in two evaluative studies discussed, and inpatients

showed improved symptoms after attendance, and one of the studies reported no further increases in self-harm in attendees.

1.6.2 What new information does this review provide?

The current review presents a comprehensive evaluation of all recent outcome literature addressing psychological interventions relevant to DSH in mental health inpatient environments. Previous reviews have not solely concentrated on this specific topic. As a result, the current review can draw more specific conclusions about elements of interventions that appear to have been particularly helpful. On the whole, longer term interventions lasting at least three months have tended to result in more sustained improvements compared to particularly brief interventions. Elements of interventions such as skills training in DBT and problem-solving approaches appear to have helped to empower patients to feel that they can cope without such close monitoring and support, and apply these skills independently. Other ways of empowering clients have included allowing them some choice about the intervention they receive, and providing them with some responsibility in the intervention process. Scott Gordon (2000) discussed how clients can be viewed as “active agents” in therapy. Ways of tailoring intervention to individuals’ needs appears important, for example, by addressing specific patient goals, and again by involving patients in the development or running of group interventions. There have been some suggestions that the combination of group and individual interventions delivered concurrently can result in enhanced effectiveness. The importance of creating and maintaining stable environments for patients whilst experiencing interventions has also been emphasised.

1.6.3 Patients with Borderline Personality Disorder diagnosis

Twelve of the studies reviewed here have used participant groups comprised of inpatients meeting criteria for Borderline Personality Disorder, BPD. However, not all inpatients who display DSH display borderline presentations, and not all inpatients with a BPD diagnosis self-harm. McGlashan et al. (2005) found that self-harm, along with effort to avoid abandonment, were the least stable DSM-IV (APA, 1994) criteria for BPD. The authors suggested that DSM-IV personality disorders were “hybrids of more stable traits and less stable symptomatic behaviours”.

1.6.4 Patient gender

Women make up the majority of participants in the outcome studies reviewed by far, and in the five studies in the current review that clearly contained participants of both genders, there were between twice as many to twelve times as many females than males. For interventions used in studies that have only contained female patients, the ability to generalise findings to male inpatients could be questioned, as it is possible that they may respond differently to the intervention. However, in studies containing male and female participants, differential effects on DSH have not been displayed.

1.6.5 Patient age

Evaluative studies of inpatient interventions for adolescents and young people are still lacking. Only two studies were found for the purpose of the current review in

which participants were younger than 18 years of age, and one other study involved an inpatient on an adolescent unit, although she was over 18 years old.

1.6.6 Trauma and deliberate self-harm

Many inpatients who display DSH will have experienced some form of trauma in their lifetimes and the DSH may be a response to trauma experiences. For example, Sansone, Gaither, and Songer (2002) found mental health inpatients with abuse histories to be more likely to display DSH, along with other BPD symptomatology. Only one study in the current review clearly implemented trauma-specific interventions, and there may be more need for trauma-focused intervention for inpatients who self-harm.

1.6.7 The inpatient environment

Some studies have considered the importance of factors other than the implementation of specific interventions in inpatient settings that could have affected outcome. For example, Bateman and Fonagy (1999) discussed the possible impact of amounts of staff time and attention given on units. Liebling and Chipchase (1996, 1999) questioned whether a therapeutic intervention could be effective in the restrictive environment of a secure inpatient setting, and considered that external events to the intervention delivery itself could interfere with progress made during intervention. Low, Jones, Duggan, Power, et al. (2001) described obstacles to delivering interventions effectively in the inpatient environment, such as therapy sessions being disturbed because there were no private rooms on the unit. They also suggested that there is limited ability for patients to improve their independence and responsibility due to institutional

restrictions. The majority of inpatients are prescribed psychiatric medication, and therefore medication effects are a confounding variable in many of the studies reviewed. However, Wheatley and Hollin (2005) controlled for medication effects and no participants in Liberman and Eckman's (1981) study were taking psychotropic medication during the intervention evaluated.

1.6.8 Limitations

What constitutes an incident of DSH varies from study to study, which makes direct comparisons between evaluations difficult. Some patients were considered to display suicidal intent with self-harming behaviour, while others were not, and suicidal intent may be difficult to ascertain in each individual case. Forms that DSH have taken have often not been made clear in many of the studies reviewed here, other than in case studies, and have often varied between patients when types have DSH have been reported.

Other issues also made direct comparisons between the studies evaluated difficult. Differences in the methodology of studies were present as some studies involved randomised controlled trials, and others did not, and both quantitative and qualitative outcome measures were used across studies. Also, the interventions evaluated used groups and individual therapy, or a mixture of the two. Not all of the studies included in this review solely focused on inpatient intervention addressing DSH, but all studies evaluated were considered to have provided relevant information to add to the evidence base regarding inpatient intervention for DSH. Some studies cited had been referred to in previous reviews, providing some repetition of information previously presented.

1.6.9 Future research

Suggestions for further research include seeking the replication of findings, particularly with regard to case studies, the use of control and comparison groups, obtaining follow-up information, and using randomised trials. As the minority of studies reviewed included male participants, and DSH is common in male as well as female inpatient populations (Jackson, 2000), interventions need to address DSH in this subgroup. More studies of inpatient interventions for young people are needed. Possible contagion effects of DSH in adolescent inpatients have been found (Helenius, Kaljonen, Kallio-Soukainen, Nokso-Koivisto, and Taiminen, 1998), and therefore such causes of DSH on inpatient units in young people may need more consideration when implementing interventions. Focusing on the importance of trauma experiences in inpatients who self-harm may also be required. Future research could incorporate both standardised measures with frequencies of DSH and qualitative information such as patients' views of interventions. Kazdin (1999) suggested that research should view clinical significance as multidimensional, including subjective evaluations of intervention by those who received it and others.

1.7 Summary and Conclusions

It is important for inpatient units to address deliberate self-harm, with or without suicidal intent, because of the high levels of risk. The current review has attempted to draw together all evaluative studies relevant to inpatient interventions for deliberate self-harm, which has not specifically been carried out in previous review literature. It has provided some explanation of how

interventions have been adapted for inpatient populations, and of how individual needs have been met for some patients. The review has demonstrated that a variety of intervention methods have been used in the area, predominantly drawing on cognitive-behavioural or psychodynamic approaches to therapy, using group and/or individual interventions, which have mostly resulted in differing levels of positive outcomes, but not for all participants. The review has discussed clinical implications of deliberate self-harm intervention in inpatient environments, and suggested important considerations for future research and evaluations in this subject area.

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Chapter 2: Empirical Paper

Nursing Staff Knowledge and Attitudes Towards Deliberate Self-Harm in Adults and Adolescents in an Inpatient Setting

Word Count: 7990 (excluding tables, figures, and references)

2.1 Abstract

Objectives. To investigate whether perceptions of self-harm behaviours are linked with emotional responses and helping behaviours.

Design. A mixed design was used, adopting predominantly quantitative methods.

Method. There were 76 nursing staff participants, including qualified and unqualified staff, who worked in either adolescent or adult secure inpatient settings within a single organisation. Participants completed vignette, knowledge, and attitudes questionnaires, related to working with patients who display deliberate self-harm. Training needs were examined, and additional comments sought.

Results. Further support was found for attributional theories suggesting that views on deliberate self-harm are linked to propensity to help, and that emotions can be a mediating factor. Staff who reported feeling more negative about patients who self-harm reported more worry about working with this patient group. There were nonsignificant trends suggesting that higher reported effectiveness in working with patients who self-harm was related to lower reported negativity and worry about working with the patient group. Unqualified nursing staff reported more negativity and worry than qualified staff. Particular gaps in knowledge were in relation to subgroups of the population at higher risk of self-harming, e.g. individuals with a history of sexual abuse. Qualitative data yielded themes of patient needs, staff needs,

reflections on working with patients who self-harm, reasons for deliberate self-harm, and reflections on intervention. Previous research findings of male staff reporting more negative attitudes than female staff, and length of work experience being associated with either increased negative or positive attitudes, were not replicated here.

Conclusion. It was suggested that training and support could be aimed at helping nursing staff, particularly unqualified staff, feel more positive and less concerned about working with patients who self-harm. There is a particular need for this in mental health inpatient settings, where self-harm is frequent, and unqualified nursing staff are important members of the staff team. Such needs of unqualified nursing staff have not been highlighted in previous research. Providing specific information regarding people at heightened risk of self-harm may also be important in helping to increase nursing staff's understanding.

2.2 Introduction

Staff attitudes can be influenced by a number of factors and affect how staff relate towards patients and clients. This study focused on staff attitudes towards deliberate self-harm, DSH, in a mental health inpatient setting for nursing staff working in inpatient units within a private health organisation.

2.2.1 Deliberate self-harm

There is considerable debate about the definition of DSH, in particular about the presence of suicidal intent (for example, Taylor, 2003). Messer and Fremouw (2008) discussed how research has found a significant proportion of people who

self-harm to report suicidal ideation at some point, and they are more at risk of suicide attempts. For the purposes of this study, DSH is defined as “self-poisoning or injury, irrespective of the apparent purpose of the act”, in accordance with the definition provided by the National Institute for Health and Clinical Excellence (NICE, 2004, p. 7). It has been reported that the UK has one of the highest rates of self-harm in Europe, at 400 per 100,000 people (Horrocks and House, 2002), and DSH has been quoted as one of the top five causes of acute medical admissions (Hawton and Fagg, 1992). Sansone, Songer, and Miller (2005) discussed higher prevalence rates for DSH in people diagnosed with Borderline Personality Disorder, BPD, and women treated for alcohol and substance abuse, and higher comorbidity rates for depression and eating disorders in those who self-harm.

2.2.2 Deliberate self-harm in mental health inpatient settings

DSH is a common phenomenon within mental health inpatient units and secure facilities, predominantly in female inpatients (for example, James and Warner, 2005; Thomson, Bogue, Humphreys, and Johnstone, 2001), although it can be as common in male inpatients. For example, White, Leggett, and Beech (1999) found a 45.5% prevalence of self-harm in male patients in one secure unit. DiClemente, Ponton, and Hartley (1991) reported a 61% prevalence rate for institutionalised young people. Penn, Esposito, Schaeffer, Fritz, and Spirito (2003) found 30% of a sample of 78 clinically referred juveniles to have engaged in DSH while incarcerated. Compared to findings in the general population, Sansone, Songer, and Miller (2007) did not find DSH to relate to particular psychiatric diagnoses amongst a sample of psychiatric inpatients.

2.2.3 Staff attitudes towards DSH

It has been found that patients who present with DSH are often regarded as more challenging than other patients (for example, Huband and Tantam, 2000). White et al. (1999) posited that, because of this, it is important for staff to receive adequate training and support to help them intervene and relate to these patients positively.

The majority of research literature looking at staff attitudes towards DSH has taken place in medical settings such as Accident and Emergency, A & E, departments of general hospitals. Ghodse (1978) and Ghodse, Ghaffari, Vaman Bhat, Galea, and Hayat Qureshi (1986) found that patients who had taken accidental overdoses were regarded more favourably than those who had taken deliberate overdoses, who in turn were viewed more positively than overdoses occurring through drug addiction. McAllister, Creedy, Moyle, and Farrugia (2002) reported a generally negative attitude from emergency department staff towards clients who self-harmed, and a correlation was found between years of experience and an empathic approach towards clients. Sidley and Renton (1996) reported 55% of a sample of nursing staff disliked working with patients who self-harm. McCann, Clark, McConnachie, and Harvey (2006) found the majority of a sample of A & E staff to report a lack of educational preparation for caring for patients who self-harm. Older and more experienced nurses were more supportive in their attitude than younger and less experienced staff. Nurses who attended in-house DSH education were also more positive. Overall, these authors concluded that attitudes appeared to be improving. Friedman et al.

(2006) reported evidence that contradicted previous research findings cited above, as unhelpful attitudes towards A & E self-laceration cases were particularly displayed by more senior staff without DSH training. There was also a correlation between declining positive attitudes and longer A & E work experience.

Some studies have used Weiner's attributional model of helping behaviour (1980, 1986) as a basis for attitude research. The first central component of Weiner's theory is that people are more likely to withhold helping behaviour from someone if the cause of their need is believed to be controllable by that individual, and if the cause originates from factors internal to them. The second component of the theory is that the relationship between one's perception of the controllability and internality factors and helping behaviour are not direct, but mediated through emotions. Therefore, if the need for help is attributed to uncontrollable factors, the potential helper feels sympathy and pity, which should lead to an offer of help. If the need for help is attributed to controllable and internal factors, then emotions such as anger result, which would lead to the denial of help. Weiner's updated theory (1986) placed an emphasis on the influence of the attributional stability of the problematic behaviour, positing that higher perceived stability means a lower propensity to help because there are low expectations for the help to result in a successful outcome.

Dagnan, Trower, and Smith (1998) found support for Weiner's (1980, 1986) theory in relation to care staff working with people with learning disabilities and challenging behaviour. They reported that optimism, negative emotions (anger,

disgust, anxiety and depression), and controllability were factors that predicted helping behaviour. However, Sharrock, Day, Qazi, and Brewin (1990) found optimism, not mediated by emotional reactions, was linked to helping behaviour. Mackay and Barrowclough (2005) tested Weiner's attributional model to try and identify influential factors in A & E staff's judgements of patients who self-harmed, and findings were consistent with Weiner's theory. The more controllable staff viewed a hypothetical patient's DSH, the greater the negative affect towards the patient, and propensity to help was lower. The more likely that DSH was considered to be a stable and repeated behaviour, the less optimism staff reported for a successful outcome as a result of their help. Also, a correlation was found between higher irritation ratings in staff who perceived higher controllability of DSH in hypothetical patients, and lower propensity for helping behaviour.

To date, the majority of studies have focused on attitudes towards DSH in adults. However, Crawford, Geraghty, Street, and Siminoff (2003) developed questionnaires to assess staff attitudes and knowledge related to DSH in adolescents. Staff who reported feeling more effective in their work felt less negative towards patients who display DSH. Gaps in staff knowledge found were in relation to unawareness that homosexual young men and those who had experienced sexual abuse were at greater risk of DSH, and that those who self-harm are at increased risk of suicide. Of their participant group, 42% perceived a need for further training about DSH, and the authors suggested that training should address the misconceptions they identified.

2.2.4 Staff attitudes in mental health inpatient settings

Comparatively little research has been conducted on staff attitudes towards DSH in mental health inpatient or forensic settings. It is possible that the attitudes of staff working in secure settings, where patients may be residents on units for months to years, may differ from the attitudes of staff working in acute admission settings, where patients' stays are much shorter. Gough and Hawkins (2000) conducted a survey of staff working in a forensic psychiatric service. They found a number of staff with negative or punitive attitudes towards DSH and its management. However, they also found that the more experience staff had of working with people who self-harm and the more training they received, the greater the perceived understanding of DSH.

2.2.5 The current study

The aim of the current study was to add to the evidence base regarding staff attitudes towards patients who self-harm in mental health inpatient settings. The attributional questionnaire using a hypothetical case vignette developed by Mackay and Barrowclough (2005) was adapted and used to ascertain whether Weiner's (1980, 1986) attributional model of helping would be supported by inpatient staff responses. The knowledge and attitudes questionnaires devised by Crawford et al. (2003) were used, and adapted for use with staff working with adult inpatients. The aim of using the knowledge questionnaire was to ascertain whether there were particular gaps in inpatient nursing staff's knowledge about DSH. The attitudes questionnaire was used to ascertain if there were any significant relationships between inpatient nursing staff's reported effectiveness, negativity and worry.

As discussed previously, many studies have found negative attitudes from staff towards adults who have displayed DSH (for example, Ghodse 1978; McAllister et al., 2002; Sidley and Renton, 1996), although it is argued that attitudes may be improving (McCann et al., 2005). Conversely, Crawford et al. (2003) found that staff from casualty departments, inpatient units, and a Child and Adolescent Mental Health Service, displayed particularly positive attitudes towards young people who display DSH. Following these apparently disparate views depending on the age group of those self-harming, the current study aimed to discover if there were significant differences between the attitudes of nursing staff working with adults who self-harm and nursing staff working with young people who self-harm. Previous research had not looked at such direct comparisons.

Mackay and Barrowclough (2005) found some differences in staff attitudes depending on gender as male staff reported more negative attitudes, in terms of lower personal optimism and higher irritation, than female staff. Any possible attitude differences depending on gender were therefore investigated in the current study. Previous studies have found relationships between length of experience in current area of work and seniority and attitudes towards DSH (for example, McAllister et al., 2002; McCann et al., 2005; Friedman et al., 2006), and therefore assessment of any relationships between level of nursing qualification or length of experience and attitudes towards DSH was also conducted. Friedman et al. (2006) assessed levels of training regarding DSH and Crawford et al. (2003) assessed perceived training needs of staff regarding

DSH. The current study also aimed to collect some information regarding nursing staff's views about how much training they received for working with patients who self-harm, and suggested additional training needs.

2.3 Research Questions

1. Do inpatient nursing staff's reported attitudes towards a patient who displays DSH provide further support for Weiner's (1980, 1986) attributional model of helping behaviour?

Hypothesis 1: It was predicted that the findings of Mackay and Barrowclough (2005) would be replicated. That is, the more controllable a patient's behaviour is viewed to be, the greater the negative affect experienced towards the patient, and the lower the propensity to help. Also, it was predicted that the more likely DSH is considered a stable, repetitive behaviour, the less optimism would be reported for a successful outcome as a result of staff input to help the patient.

2. Are there any significant relationships between inpatient nursing staff's reported effectiveness, negativity and worry with regard to inpatients who display DSH?

Hypothesis 2: Following Crawford et al.'s (2003) previous findings, it was predicted that staff who felt more effective in their work with self-harmers would feel less negative towards patients who display DSH.

3. Are there any significant differences between nursing staff attitudes from two mental health inpatient areas, providing care for adolescents and adults respectively?

Hypothesis 3: It was predicted that there would be some differences in attitudes displayed by nursing staff working with adolescents compared to the attitudes of staff working with adults, with a trend towards more positive attitudes towards adolescents and less positive attitudes towards adults.

4. Are there any significant differences in attitudes and knowledge depending on gender or level of qualification amongst inpatient nursing staff?

Hypothesis 4: It was predicted that male staff would display more negative attitudes than female staff, as they were previously found to experience less personal optimism and higher irritation than female staff. No clear conclusions could be made on the basis of previous research findings regarding attitudes and knowledge related to level of qualification, but relationships between these factors were investigated here.

5. Are there significant relationships between length of experience in current area of work and attitudes or knowledge?

Hypothesis 5: To date, significant relationships between attitude and length of experience have been found, although there has been conflicting data on the nature of these relationships. In line with previous research, it was predicted that length of experience in staff's current area of work would be associated with measures of attitudes towards DSH. The relationship between length of experience and knowledge regarding DSH was not previously investigated.

6. Are there any significant gaps in nursing staff's knowledge about deliberate self-harm and what particular training needs are perceived by nursing staff to help equip them further for working with patients who self-harm?

Hypothesis 6: Previous findings have suggested gaps in knowledge with regard to high risk groups and future suicide risk in adolescents, so it was predicted that these would be particular areas where there were gaps in knowledge in the current study.

2.4 Method

2.4.1 Participants

All nursing staff working in the adolescent services and the men's and women's adult services at St Andrew's Healthcare, Northampton, were potential participants. There were 647 nursing staff identified as working in these areas, of whom 293 were working in the adolescent units and 354 were working in the adult units. Of these staff, 271 were qualified nursing staff, 122 in adolescent services, 149 in adult services, and 376 were unqualified Healthcare Assistants, Senior Healthcare Assistants, and Nursing Assistants, 171 in the adolescent services, 205 in the adult services. It was not possible to ascertain the number of male and female staff in total as it was not possible to identify gender on the basis of names in all cases.

2.4.2 Measures

Three questionnaires were contained in the pack sent to all potential participants. See Appendix A for an example of the questionnaire pack. A demographics sheet asked participants to identify their gender, profession, Healthcare Assistant

or qualified Nurse, and length of experience. It was considered that asking for the age of participants, along with other demographic information, may make staff identifiable, so this was excluded. It was estimated that the questionnaire pack would take approximately 30 minutes to complete.

Vignette Questionnaire

The first questionnaire comprised one case vignette and corresponding measures, adapting methodology used by Mackay and Barrowclough (2005). Age, gender, ethnicity, and the type of DSH displayed were consistent across all vignettes presented. Self-harm has been reported to be most common in females aged between 15 and 19 years (for example, Hawton, 1992), and therefore the case vignette depicted a 17 year-old female, as this was the median age for this group. Overdose has been cited as the most common method of DSH in the general population (for example, Hawton et al., 2001), although no clear data on the most typical form of DSH displayed in inpatients was found. Therefore, the hypothetical patient was described as having taken an overdose of tablets. No clear evidence as to the ethnicity of people who most commonly display DSH in the general population or in inpatient populations in the UK could be found. The patient in the vignette is described as being White, as it was considered that this was the most common ethnic background for a young female inpatient in this setting. The stability of self-harm was manipulated by changing the reported number of times the patient had previously displayed DSH, and the incident described was either the first time or the sixth time that the patient had displayed DSH. Controllability of the precipitant to self-harm was manipulated by adding a piece of information, either that the patient's mother had recently died, or that

she had accumulated huge financial debt for her family. Each participant received one of the stability statements and one of the controllability statements in their case vignette, and therefore four versions of the vignette were used. Participants were randomly assigned one version.

Questions 1 - 5 on the Vignette Questionnaire were an adaptation of the Attributional Style Questionnaire (ASQ) following Peterson et al. (1982) and Mackay and Barrowclough (2005). Nursing staff participants were asked to generate their own cause of self-harm in a hypothetical patient and to rate the cause on a scale corresponding to the dimensions of controllability, stability of cause, stability of outcome, and internality.

Questions 6 - 9 related to the Emotional Response Rating Scale, devised following Mackay and Barrowclough (2005), who used emotional responses identified by Weiner (1980) as impacting on helping behaviours. The Optimism/Pessimism Scale followed Mackay and Barrowclough, who devised questions following Moores and Grant (1976), comprised of questions 10 and 11 on the Vignette Questionnaire. The Helping Behaviour Scale following Mackay and Barrowclough was used, asking questions regarding staff's willingness to prioritise the person described in the vignette, to offer extra time and support, and the likelihood of initiating contact with another appropriate professional. Questions 12 - 14 related to this scale. Mackay and Barrowclough (2005) discussed how staff feeling that they do not have the appropriate skills to deal with acts of DSH may be an additional factor motivating staff's helping behaviour. Therefore, a question addressing this was included as Question 15.

Knowledge and Attitudes Questionnaires

Modified versions of the knowledge and attitudes questionnaires developed by Crawford et al. (2003) were used, and the wording altered to be applicable to adult service staff. Searches on the Internet and of research papers were carried out to verify that the knowledge questionnaire answers were still valid when applied to the adult population. Nursing staff working within adult services received the adult version of the knowledge and attitudes questionnaires, and staff working within adolescent services received the adolescent version of the questionnaires.

Training and additional information

One open question was presented at the end of the questionnaire pack to collect qualitative information from participants regarding working with patients who self-harm, along with two multiple choice questions pertaining to perceived training needs.

2.4.3 Design

This study used a mixed design, although between-groups and within-groups differences were analysed using quantitative methods. Case vignettes of a hypothetical patient displaying DSH were used to see whether manipulating the controllability of the precipitant for self-harm and the stability of its occurrence affected staff's attributions regarding the patient described. The Attitudes Questionnaire was administered with the aim of drawing some conclusions about relationships between staff's self-reported effectiveness, worry and

negativity in relation to working with patients who self-harm. It was also possible to look at possible relationships between gender, occupational experience, and knowledge about DSH, and any of the above variables outlined. A relatively small amount of qualitative information was gathered through one open question about working with people who display DSH, along with two multiple choice questions regarding training needs. Using a largely quantitative approach allowed for information to be gathered regarding many variables in the most time effective manner, from a large participant group.

All data was collected through returned questionnaire packs. Ratings on Likert scales were gathered from the Vignette Questionnaire and the Attitudes Questionnaire. True/false responses were obtained for the Knowledge Questionnaire items, and numbers of correct responses calculated. The SPSS (2006) software package was used to analyse the quantitative data. G*POWER 3 (Faul, Erdfelder, Lang, and Buchner, 2007) was used to calculate effect sizes and observed power. Thematic analysis (Braun and Clark, 2006) was used to analyse the qualitative data.

2.4.4 Procedure

Ethical approval for this study was obtained from Coventry University Ethics Committee and Leicestershire, Northamptonshire, and Rutland NHS Ethics Committee (see Appendix B for approval letters). Contact with St Andrew's Healthcare research committee was made via letter and e-mail for advice and permission to conduct the study. Nurse Managers at St Andrew's Healthcare were contacted to ask for initial permission for nursing staff to be approached to

take part. Assistance from the Personnel department in the hospital was provided to access contact details for potential participants. All nursing staff identified as working on adolescent and adult units within St Andrew's Healthcare were sent a pack with a covering letter (see Appendix C), the Participant Information Sheet (see Appendix D), Informed Consent Sheet (see Appendix E), and questionnaire pack (see Appendix A). If they agreed to take part, staff were asked in the Patient Information Sheet to complete the Informed Consent Sheet and questionnaire pack in their own time, and to return the completed forms within three weeks. Contact information was given for any support or debriefing, and it is planned that feedback on the outcome of the research will be offered in the form of printed information. All responses were anonymised.

2.5 Results

Seventy-six staff completed and returned questionnaires, which constituted a 12% response rate. Table 2.1 displays participant details in terms of service, gender, and qualification level. One participant completed the Vignette Questionnaire but not the subsequent measures, and therefore there were 75 sets of responses to the Knowledge and Attitudes Questionnaires. The mean length of experience for all participants in their current area of work was 6.4 years ($SD = 4.75$ years).

Table 2.1 - Participant Information

	Adult Service Staff	Adolescent Service Staff	Total
Male Staff	10	7	17
Female Staff	26	19	45
Gender not given	13	1	14
Qualified Nurses	28	9	37
Unqualified Staff	21	18	39
Group Total	49	27	76

2.5.1 Hypothesis 1 – Investigating the attributional model of helping behaviour

Vignette Questionnaire - Effects of DSH precipitant and frequency on attributional style

The impact of precipitant and frequency of DSH presented in the case vignettes on the control, stability of cause, stability of outcome, and internality ratings (responses to questions 2-5 on the Vignette Questionnaire) was initially screened by conducting independent-samples t-tests on the mean scores on these dimensions for adult and adolescent unit staff. No significant differences between these mean scores were found, and therefore the data for the two groups were collapsed for further analysis. The data were subjected to 2 (Precipitant) x 2 (Frequency) factorial analyses of variance (ANOVAs). The results of these ANOVAs are presented in Table 2.2. It should be noted that higher mean scores on the internality dimension indicated lower internality. The only statistically significant result was the interaction effect between precipitant to DSH and frequency of DSH on the internality dimension, $F(1, 72) = 4.56$, $MSE = 2.03$, $p < .05$. Therefore, internality ratings were influenced by a combined effect of the precipitant and frequency information given. Table 2.3 and Figure 2.1 display further details of the interaction. The mean scores indicated that the DSH

was viewed as more due to external factors when it was the first occurrence and the precipitant given was bereavement. Conversely, it was viewed as more due to internal factors when it was the first occurrence of DSH, and the precipitant was financial debt. However, planned post-hoc comparisons showed a non-significant effect for precipitant on internality scores, $F(1, 74) = 2.28$, $MSE = 2.12$, $p = .14$, in addition to a non-significant effect for frequency of DSH on internality scores, $F(1, 74) = 0.34$, $MSE = 2.17$, $p = .56$.

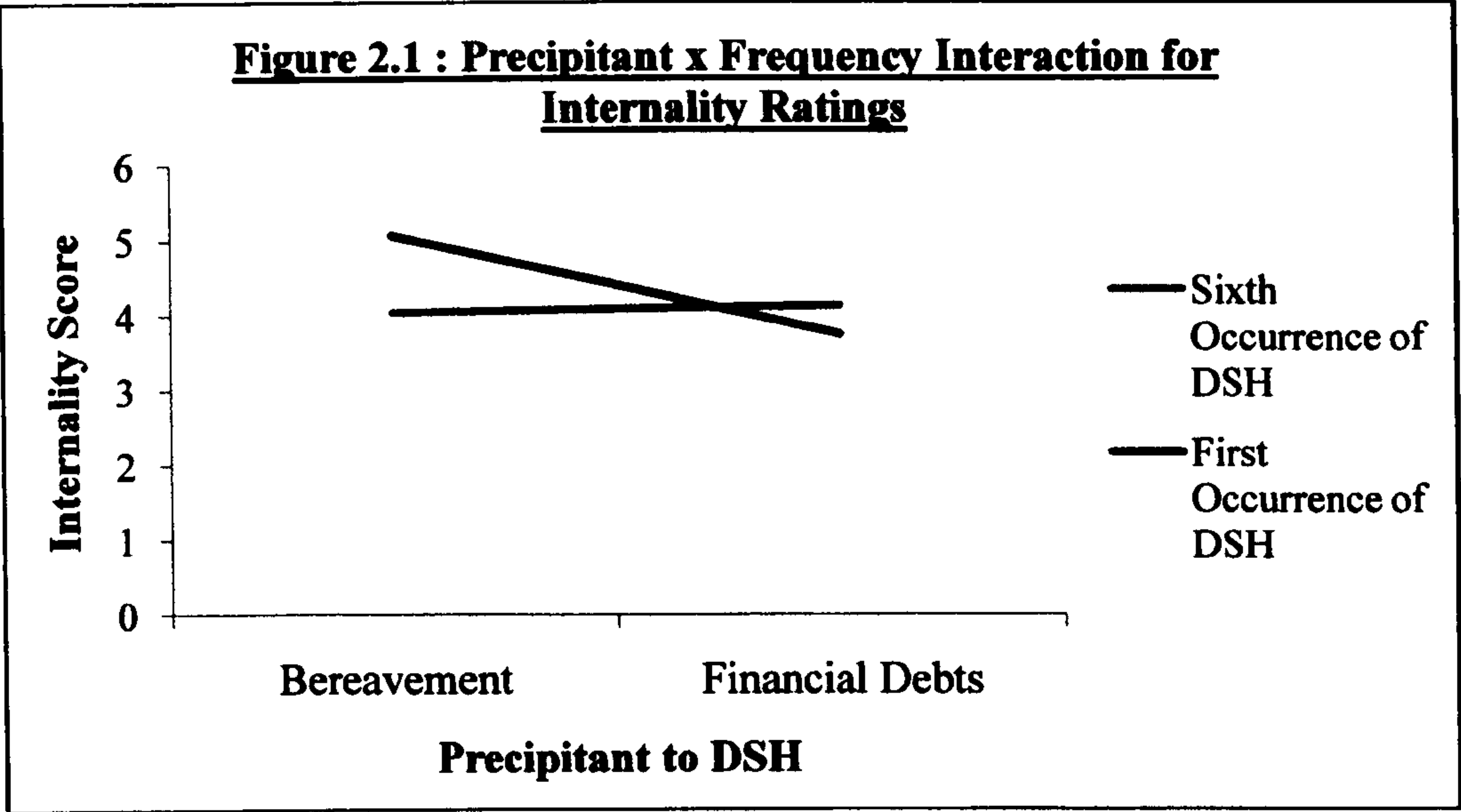
Table 2.2 – Means, Standard Deviations, and Interactions For Effects of Precipitant and Frequency of DSH on Attributional Style Ratings

	Precipitant to DSH		Frequency of DSH		
Dimension (observed power following F value)	Bereavement	Financial Debts	First Occurrence	Sixth Occurrence	Precipitant x Frequency Interaction
Control	4.26 (1.84)	4.41 (1.72)	4.59 (1.73)	4.14 (1.79)	$F(1, 72) = 2.32$ (.32)
	$F(1, 72) = 0.01$ (.05)		$F(1, 72) = 1.48$ (.22)		
Stability of Cause	5.00 (1.57)	5.32 (1.21)	5.03 (1.31)	5.29 (1.45)	$F(1, 72) = 0.04$ (.05)
	$F(1, 72) = 1.15$ (.19)		$F(1, 72) = 0.81$ (.14)		
Stability of Outcome	5.86 (1.56)	5.66 (1.04)	5.47 (1.54)	5.98 (1.02)	$F(1, 72) = 0.10$ (.06)
	$F(1, 72) = 0.23$ (.08)		$F(1, 72) = 2.76$ (.38)		
Internality	4.46 (1.54)	3.95 (1.38)	4.29 (1.53)	4.10 (1.43)	$F(1, 72) = 4.56^*$ (.56)
	$F(1, 72) = 3.42$ (.45)		$F(1, 72) = 0.91$ (.16)		

* $p < .05$, partial eta squared = .06
(other results $p \geq .05$; $n = 76$; all effect sizes \leq partial eta squared .06)

Table 2.3 – Group Means to Display Precipitant x Frequency Interaction for Internality Ratings

	Precipitant to DSH	
Frequency of DSH:	Bereavement	Financial Debts
First Occurrence	5.07 (<i>n</i> = 14)	3.75 (<i>n</i> = 20)
Sixth Occurrence	4.05 (<i>n</i> = 21)	4.14 (<i>n</i> = 21)



Vignette Questionnaire - Control and internality attributions, emotional responses and helping behaviour correlations

A series of Pearson’s product moment correlations were calculated to examine the associations between the attributional variables and emotional responses for the adult and adolescent unit staff respectively, and the results are displayed in Tables 2.4 and 2.5. These analyses indicated that there were significant associations between control and sympathy ($r = -.54, p < .01$), and between control and pity ($r = -.50, p < .01$) for adult unit staff, with lower ratings of control over DSH being associated with greater sympathy and greater pity. There were significant positive correlations between internality and pity ($r = .40, p < .01$), and internality and helping ($r = .38, p < .01$) for adult unit

staff, with scores indicating that DSH was perceived as more due to external factors in association with higher pity and helping scores. There was a significant negative correlation between irritation and adequate skills for adult unit staff ($r = -.37, p < .01$), with lower irritation being associated with higher perceived adequate skills to deal with the DSH act described in the vignette. There were significant positive associations between sympathy and pity for adult unit staff ($r = .59, p < .01$), and between sympathy and adequate skills for adolescent unit staff ($r = .46, p < .05$).

Vignette Questionnaire - Stability attributions, optimism, and helping behaviour

Correlational analyses examined the relationship between stability of cause of DSH and the likelihood of repetition and staff optimism. There was a significant negative correlation between stability of cause and optimism for follow-up for adult unit staff ($r = -.37, p < .01$), with lower ratings for the likelihood of the cause of DSH persisting, being associated with higher optimism for follow-up. There was also a significant correlation between stability of outcome and optimism for follow-up for this staff group ($r = -.33, p < .05$), indicating that lower ratings of the likelihood that DSH was a stable, repeated, behaviour in the patient were associated with higher optimism for subsequent treatment to be helpful. In addition, there was a significant positive correlation between optimism for follow-up and helping behaviour for adult unit staff ($r = .37, p < .01$), with higher perceived optimism for follow-up associated with higher helping behaviour scores. No significant correlations between these variables were found for adolescent unit staff.

Table 2.4 – Correlations Between Vignette Questionnaire Variables for Adult Unit Staff

	2	3	4	5	6	7	8	9	10	11	12
1. Control	-.30*	-.13	-.08	-.13	-.54**	-.50**	.03	-.19	.10	-.04	.11
2. Stability of Cause		.60**	.02	-.02	-.05	.14	.19	-.13	-.37**	-.16	-.22
3. Stability of Outcome			-.21	.10	-.27	-.11	.18	-.11	-.33*	-.22	-.05
4. Internality				.06	.21	.40**	.17	.05	.11	.38**	-.13
5. Irritation					.00	.06	.53**	-.30*	-.14	.03	-.37**
6. Sympathy						.59**	-.16	.24	.21	.26	-.07
7. Pity							.19	.06	.15	.25	-.14
8. Frustration								-.17	-.21	-.01	-.26
9. Personal Optimism									.57**	.28	.26
10. Optimism for Follow-up										.37**	.29
11. Helping											.03
12. Adequate Skills											

* $p < .05$

** $p < .01$

Table 2.5 – Correlations Between Vignette Questionnaire Variables for Adolescent Unit Staff

	2	3	4	5	6	7	8	9	10	11	12
1.Control	.19	.06	-.23	.17	-.19	.12	.29	.06	-.35	-.30	-.15
2. Stability of Cause		.57**	.56**	-.12	-.12	.53**	-.06	-.29	-.36	.23	-.03
3. Stability of Outcome			.31	-.18	-.06	.31	-.09	-.30	-.21	-.00	-.05
4. Internality				-.25	.24	.22	-.27	.01	-.14	.40	.18
5. Irritation					-.14	-.12	.78**	.10	-.05	-.23	-.24
6. Sympathy						.06	-.23	.31	.34	.25	.46*
7. Pity							-.05	-.22	-.01	-.04	-.12
8. Frustration								.09	-.05	-.35	-.32
9. Personal Optimism									.29	.09	.22
10. Optimism for Follow-up										.22	.48
11. Helping											.32
12. Adequate Skills											

**p* < .05

***p* < .01

2.5.2 Hypothesis 2 – Investigating the relationships between effectiveness, negativity and worry

Descriptive data and between-group comparisons for the Attitudes Questionnaire are presented in Table 2.6. Participants reported feeling reasonably effective in managing DSH, as all group mean effectiveness scores were between 11 and 12 out of 15. Negativity scores were low, between 3 and 6 out of 15 on average. Worry scores were also low, with mean scores of between 2 and 4 out of 9. Linear regression was carried out to determine the predictability of one variable from another from the knowledge, effectiveness, negativity, and worry variables. There was no predictive value of the three attitude dimensions on knowledge scores. The relationship between effectiveness and negativity was not significant, but did approach significance, ($B = -.22$, $F(1, 73) = 3.71$, $p = .06$, observed power = .43), in the direction of higher reported effectiveness being associated with lower reported negativity. Similarly, the relationship between effectiveness and worry approached significance, ($B = -.22$, $F(1, 73) = 3.71$, $p = .06$, observed power = .43), in the direction of higher reported effectiveness being associated with lower reported worry. There was a perfect positive correlation between negativity and worry, indicating that higher negativity was associated with higher worry ($B = 1.00$, $F(1, 73) = 1.70$, $p < .01$). This relationship was found for all subgroup comparisons.

Table 2.6 – Mean Scores and Standard Deviations of Attitudes

Mean Score (SD):	All Participants	Adult Unit Staff	Adolescent Unit Staff	Male Staff	Female Staff	Qualified Staff	Unqualified Staff
Questionnaire Dimension (maximum score):							
Effectiveness (15)	11.57 (1.79)	11.54 (1.68)	11.63 (2.00)	11.69 (2.28)	11.51 (1.71)	11.73 (1.72)	11.42 (1.86)
Negativity (15)	4.15 (2.38)	3.92 (2.39)	4.59 (2.34)	4.46 (3.31)	4.06 (1.76)	3.40 (1.72)	5.08 (2.21)
Worry (9)	3.11 (1.78)	2.94 (1.79)	3.44 (1.79)	3.34 (2.48)	3.04 (1.32)	2.55 (1.29)	3.81 (1.65)

2.5.3 Hypothesis 3 – Comparisons between adult and adolescent unit staff

Group comparisons between Vignette Questionnaire responses

One-way between-groups multivariate analysis of variance (MANOVA) was performed to evaluate differences in scores on questions 6-15 of the Vignette Questionnaire. The eight dependent variables were irritation, sympathy, pity, frustration, personal optimism, optimism for follow-up, helping, and perceived adequate skills. The independent variables were staff unit group, adult or adolescent. No statistically significant differences were found between scores on any of the dependent variables between adult and adolescent unit staff.

Attitudes Questionnaire responses

Adult unit staff reported a similar level of effectiveness in managing DSH to adolescent unit staff (11.54 compared to 11.63), but adolescent unit staff reported slightly higher negativity and worry than adult unit staff (4.59 and 3.44 compared to 3.92 and 2.94 respectively). Independent samples t-tests were conducted to compare the mean scores between adult and adolescent unit staff. No significant differences were found.

Knowledge Questionnaire responses

Independent samples t-tests were conducted to compare knowledge questionnaire scores between staff unit groups. No significant differences were found in this analysis. The results for the comparison between staff unit groups was adult unit staff ($M = 7.27$, $SD = 1.55$) and adolescent unit staff ($M = 7.11$, $SD = 1.48$); $t(74) = -.42$, $p = .67$ (two-tailed), observed power = .85.

2.5.4 Hypothesis 4 – Comparisons between gender and level of qualification

Group comparisons between other Vignette Questionnaire responses

One-way between-groups multivariate analysis of variance (MANOVA) was performed to investigate differences in scores on questions 6-15 of the Vignette Questionnaire, on the basis of staff gender and qualification level, qualified or unqualified nursing staff. The eight dependent variables were irritation, sympathy, pity, frustration, personal optimism, optimism for follow-up, helping, and perceived adequate skills. No statistically significant differences were found between scores on any of the dependent variables.

Attitudes Questionnaire responses

Female staff reported slightly lower effectiveness, negativity and worry than male staff. Qualified staff reported higher effectiveness, lower negativity and lower worry than unqualified staff. Independent samples t-tests were conducted to compare mean scores between gender and qualification level. There were no significant differences between attitudes scores for male and female staff, but a significant difference in negativity scores between qualified staff ($M = 3.40$, $SD = 1.72$) and unqualified staff ($M = 5.08$, $SD = 2.21$); $t(73) = -3.66$, $p < .01$ (two-tailed), $d = .86$, was evident. Further, there was a significant difference in worry scores between qualified staff ($M = 2.55$, $SD = 1.29$) and unqualified staff ($M = 3.81$, $SD = 1.65$); $t(73) = -3.69$, $p < .01$ (two-tailed), $d = .86$. There were no significant differences between qualified and unqualified staff on effectiveness scores.

Knowledge Questionnaire responses

Independent samples t-tests were conducted to compare the Knowledge Questionnaire scores between male and female staff, and qualified and unqualified staff. No significant differences were found when comparing between male staff ($M = 6.94$, $SD = 1.43$) and female staff ($M = 7.20$, $SD = 1.50$); $t(60) = -.61$, $p = .54$ (two-tailed), observed power = .86. Similarly, there were no significant differences between qualified staff ($M = 7.49$, $SD = 1.37$) and unqualified staff ($M = 6.95$, $SD = 1.62$); $t(74) = 1.56$, $p = .12$ (two-tailed), observed power = .85.

2.5.5 Hypothesis 5 – Investigating length of work experience

Vignette Questionnaire responses

The relationship between length of work experience and all of the Vignette Questionnaire response dimensions was investigated using Pearson product-moment correlation coefficients. No significant correlations were found.

Attitudes Questionnaire responses

The relationships between length of work experience and effectiveness, negativity, and worry scores were investigated using Pearson product-moment correlation coefficients. No significant correlations were found.

Knowledge Questionnaire responses

The relationship between length of work experience and knowledge scores was analysed using Pearson product-moment correlation. A significant correlation

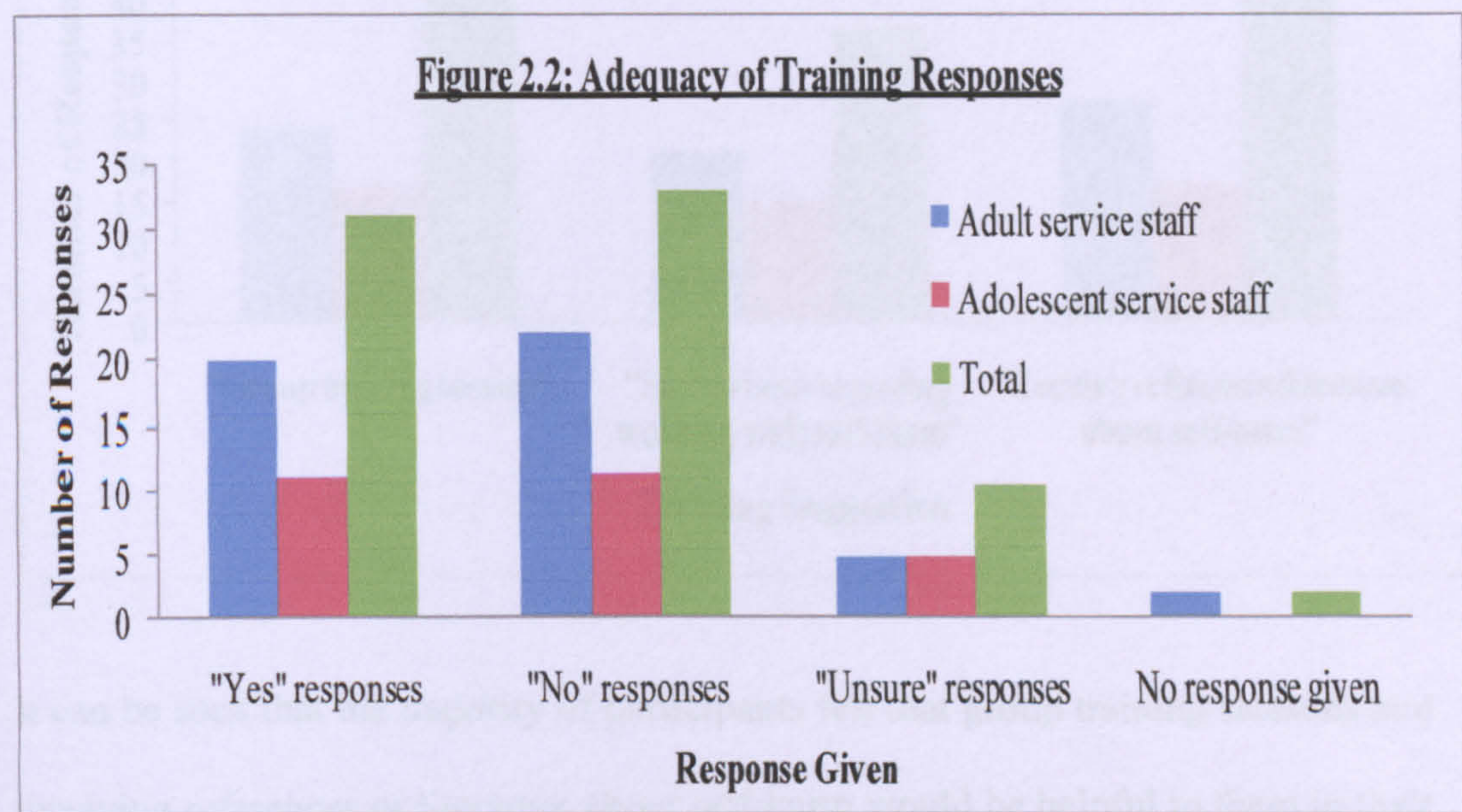
was not found between the two variables, $r = .12$, $n = 76$, $p = .30$, observed power = .70.

2.5.6 Hypothesis 6 – Gaps in staff knowledge

The average number of correct responses on the Knowledge Questionnaire was 7 out of 11 (64%) for all participants, with scores ranging between 4 and 10 out of 11. The same three questions received the lowest number of correct responses in participants from both adult and adolescent units: Question 3 - *Adults/Children and adolescents who have been sexually abused are no more likely to self-harm than the general population* (false); Question 7 - *Self-harm is more likely to occur among adults/young people who are socio-economically deprived* (true); and Question 8 - *Gay men/Gay young men are no more likely to self-harm than the general population* (false).

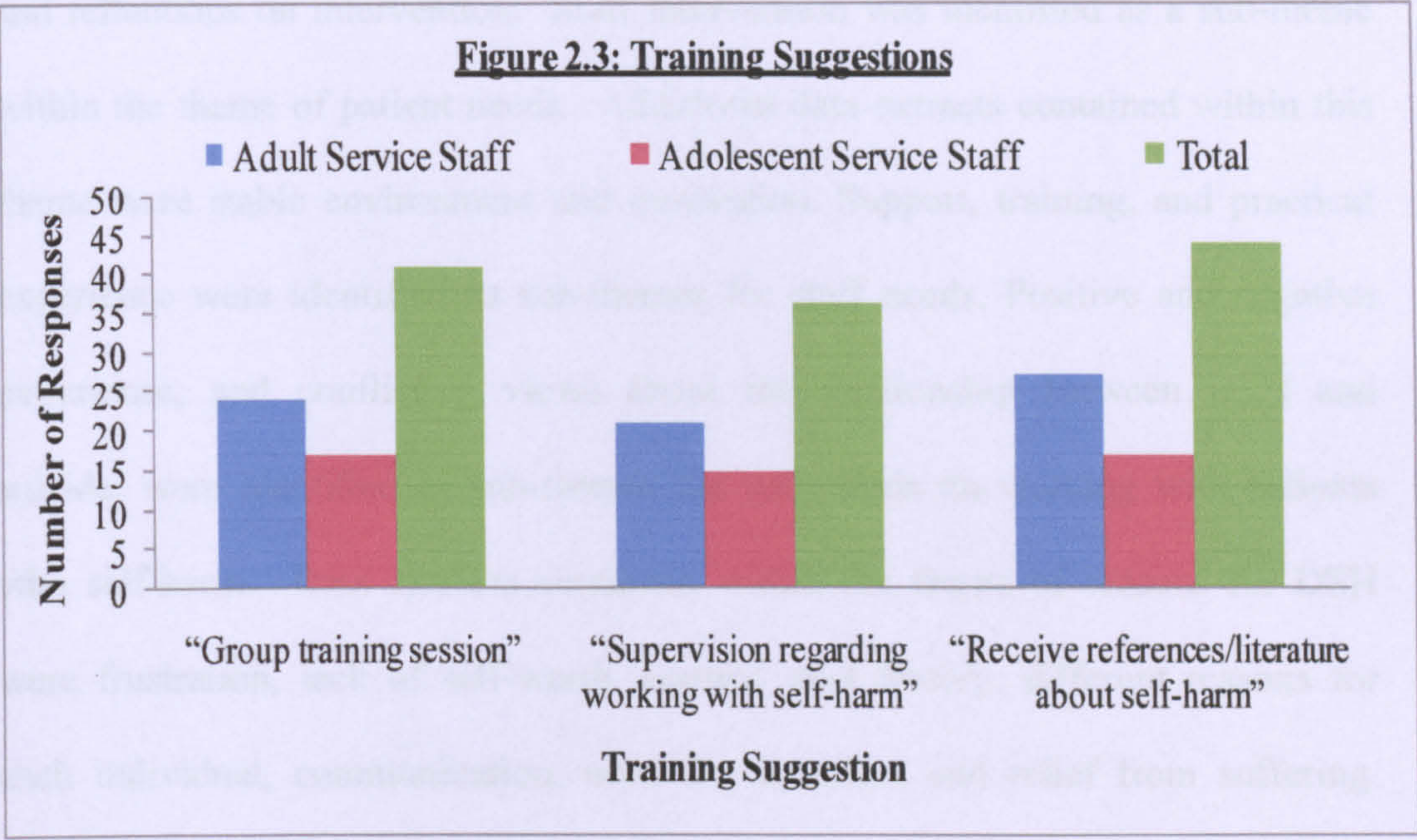
2.5.7 Training needs

Figure 2.2 displays responses to the question, “Do you feel you receive adequate training to prepare you for working with patients who self-harm?”.



It can be seen that the amount of participants who reported that they felt they received adequate training in preparation for working with self-harming patients was roughly equivalent to those who reported that they did not receive adequate training. Slightly more adult service staff reported feeling that they did not receive adequate training, but responses were comparable between adult and adolescent service staff.

Figure 2.3 displays responses provided to the question, “Is there any particular additional training or support that would help equip you further for working with patients who self-harm?”. Participants could endorse more than one option.



It can be seen that the majority of participants felt that group training sessions and receiving references or literature about self-harm would be helpful to them in their work. A large proportion of the participant group also felt that supervision regarding working with individuals who self-harm would be beneficial.

Other suggestions for particular training or support that adult and adolescent service staff provided are listed in Appendix F.

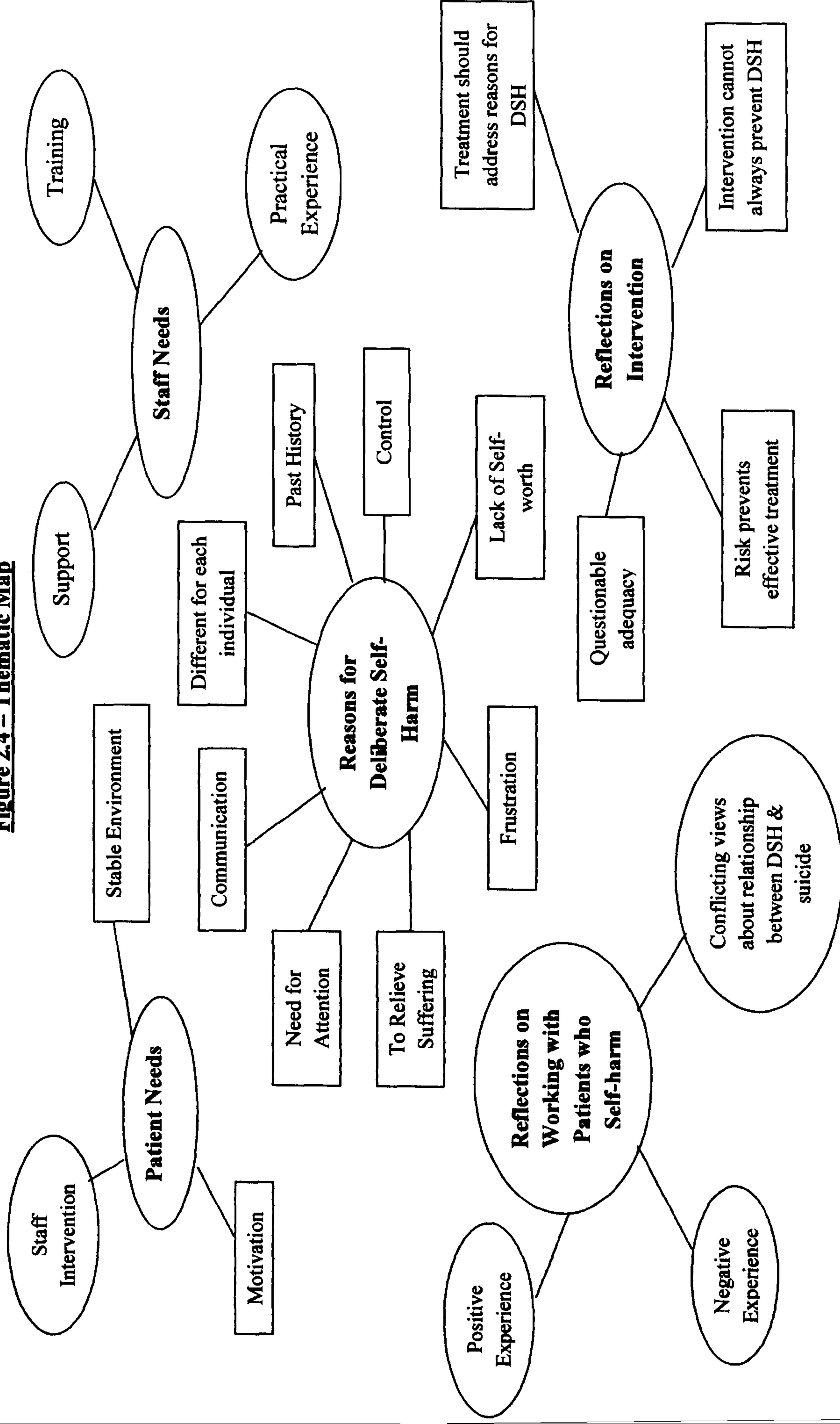
2.5.8 Qualitative analysis

A preliminary thematic analysis, following Braun and Clarke (2006), was conducted on the qualitative information obtained through responses to the question: *“Are there any further comments you would like to make regarding your experience/feelings about working with patients who self-harm?”*. All responses are presented in Appendix G. Five main themes were identified: patient needs, staff needs, reflections on working with patients who self-harm, reasons for DSH,

and reflections on intervention. Staff intervention was identified as a sub-theme within the theme of patient needs. Additional data extracts contained within this theme were stable environment and motivation. Support, training, and practical experience were identified as sub-themes for staff needs. Positive and negative experience, and conflicting views about the relationship between DSH and suicide, were identified as sub-themes for reflections on working with patients who self-harm. Data extracts contained within the theme of reasons for DSH were frustration, lack of self-worth, control, past history, different reasons for each individual, communication, need for attention, and relief from suffering. Reflections on intervention included comments that intervention cannot always prevent DSH, questionable adequacy, risk prevents effective treatment, and treatment should address reasons for DSH. Figure 2.4 presents the thematic map displaying the themes, sub-themes and extracts described.

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Figure 2.4 – Thematic Map



2.6 Discussion

2.6.1 Discussion of current findings

The initial research question was whether inpatient nursing staff's reported attitudes towards a patient who displays DSH would provide further support for Weiner's (1980, 1986) attributional model of helping behaviour. The current study did not fully replicate the findings of Mackay and Barrowclough (2005), as neither control nor helping behaviour were associated with negative affect. However, further support for Weiner's model was attained. For adult unit staff, the more uncontrollable that the patient's DSH was viewed, the more sympathy and pity were experienced. Also, more pity was experienced and higher helping responses elicited, if the DSH act was considered to be explained more by external factors. There were no findings suggesting that stability of DSH was directly associated with propensity to help. However, less optimism for help being effective was experienced when the cause and outcome of the DSH was viewed as more stable, and optimism for follow-up was associated with propensity to help responses, so stability and helping were indirectly related. The results suggested some involvement of emotions in mediating helping responses, supporting Weiner, but optimism and help were also directly related, providing some support for Sharrock et al's (1990) findings that helping behaviour is not necessarily mediated by emotions. For the participant group as a whole, manipulating the precipitant and frequency of DSH in the Vignette Questionnaire significantly affected perceived internality, whether the DSH act was viewed to be due to factors that were internal or external to the patient, but no other attributional style measures.

The second question examined whether there are any significant relationships between inpatient nursing staff's reported effectiveness, negativity and worry with regard to inpatients who display DSH. Crawford et al's (2003) findings were not replicated here as predicted. There was not a significant association between effectiveness and negativity, although there was a nonsignificant result suggesting that staff who reported feeling more effective in their work with patients who self-harm reported less negativity towards those who display DSH, which was in line with Crawford et al's findings. In addition, there was a nonsignificant result suggesting that staff who reported feeling more effective in their work with patients who self-harm reported less worry about working with this patient group. Negativity and worry were strongly associated for all staff who participated, indicating that staff who reported higher negativity also reported higher worry with regard to working with patients who self-harm.

The third area of enquiry was regarding whether there were any significant differences between nursing staff attitudes from two mental health inpatient areas, providing care for adolescents and adults respectively. The predicted results of more positive attitudes from adolescent unit staff relative to adult unit staff were not found. There were no significant differences in the Vignette Questionnaire scores depending on staff group. However, there were differences in the correlations between attitude factors on this questionnaire, as the majority of significant associations were found for adult unit staff but not adolescent unit staff. These differences may be attributable to the difference in sample sizes for the two groups, as many fewer adolescent unit staff participated. For the

Attitudes Questionnaire, there was a nonsignificant result indicating that higher negativity, against predictions made, and worry, were experienced by adolescent unit staff.

The fourth research question was regarding whether there were any significant differences in attitudes and knowledge depending on gender or level of qualification, amongst inpatient nursing staff. No significant differences in attitudes were found in terms of male staff displaying more negativity than female staff towards patients who self-harm, as was predicted in Hypothesis 4. However, there was a nonsignificant trend indicating that female staff reported lower effectiveness, negativity and worry than male staff. No significant gender differences were found in attitudes scores or for knowledge about DSH. There were no significant results indicating that level of staff qualification was related to perceived effectiveness in working with patients who self-harm. However, there were significant differences between qualified and unqualified staff on the negativity and worry scores in the Attitudes Questionnaire, indicating that unqualified staff reported more negativity and worry about working with people who display DSH than qualified nursing staff.

The fifth research question asked whether there were any significant relationships between length of experience in current area of work and attitudes or knowledge. Hypothesis 5 was not upheld as no significant relationships were found between length of experience and attitudes towards DSH as was predicted. There was no relationship found between length of experience and knowledge about DSH.

The final area of enquiry was examining any significant gaps in nursing staff's knowledge about DSH and what particular training needs are perceived by nursing staff to help equip them further for working with patients who self-harm. As was predicted in Hypothesis 6, and in line with previous findings found for staff working with adolescents (Crawford et al., 2003), particular gaps in knowledge were found from both the adult and adolescent unit staff groups. Gaps in knowledge were with regard to groups of people at heightened risk of DSH (those with histories of sexual abuse, the socioeconomically deprived, and homosexual males) as was predicted. However, there were no particular gaps in knowledge regarding future suicide risk, as had previously been found.

In summary, further support was found for attributional theories suggesting views on DSH are linked to individuals' propensity to help, and for a mediating role of emotions in this association. The results of the current study established that these theories are applicable to staff working with patients in a mental health inpatient setting. Staff who reported feeling more negative about patients who self-harm reported more worry about working with this patient group. There were nonsignificant trends suggesting that staff who reported feeling more effective in their work with patients who self-harm reported less negativity and worry about working with the patient group, although this was not necessarily the case for female staff. Unqualified nursing staff reported more negativity and worry in working with patients who display DSH than qualified staff. Particular gaps in knowledge found were in relation to subgroups of the population who are at higher risk of self-harming. It is also important to acknowledge that the current study did not replicate previous research findings that have suggested that there

are more positive attitudes towards adolescents and more negative attitudes towards adults who self-harm, higher negativity from male staff, and significant differences in attitudes dependent on length of work experience, establishing that these findings have not been found with nursing staff across a large inpatient organisation.

2.6.2 Training needs

The results from the Attitudes Questionnaire suggested that training and support to help unqualified staff feel less negative and concerned about working with patients who self-harm may be particularly important. Results from the Knowledge Questionnaire suggested that information about individuals at increased risk of self-harming may also be an important inclusion in training. Equal numbers of participants reported that they felt they did and did not receive adequate training about DSH. Many participants endorsed all of the suggested methods of training: via group format, supervision, and receiving relevant references and literature, and some participants provided clear suggestions for particular topics that training may address.

A small amount of qualitative data was obtained through asking participants for further comments regarding their experience and feelings about working with patients who self-harm. Preliminary thematic analysis of this data yielded themes of patient needs, staff needs, reflections on working with patients who self-harm, reasons for DSH, and reflections on intervention. This data may provide further ideas to incorporate into staff training topics.

2.6.3 Limitations

There was a lower response rate of returned questionnaires for the study than expected. This may have been attributable to the use of the Informed Consent Sheet, which compromised the anonymity of participants, and potential participants may not have participated due to their knowledge that completing and returning the Informed Consent Sheet would make their responses identifiable. This may have also resulted in participants being reluctant to report negative attitudes towards patients who self-harm.

There were differences in the sample sizes of the subgroups contained within the whole participant group. More adult than adolescent unit staff participated, which may have been partly attributable to the fact that the adolescent unit had recently been surveyed for another study. There were also more female than male staff participants, which was not unexpected as there is still a tendency for more females to work as nursing professionals. Gender information was not provided by 14 participants. It is possible that these participants felt that they may be identifiable in some way by providing this information or that they felt judgements would be made about their responses dependent upon their gender.

Irritation and frustration ratings on the Vignette Questionnaire were significantly correlated for the whole participant group. It was considered that these two emotions would typically be experienced in conjunction with one another. Therefore, the need for the inclusion of both measures could be questioned. Qualitative information provided by participants indicated that the Vignette Questionnaire, and other measures presented, were viewed by some as too general

and simplistic and as failing to take into account the complexity of self-harm and the skills and qualities required to work in inpatient environments. The raw qualitative data is presented in Appendix G. The analysis of the Vignette Questionnaire could have been strengthened by the use of mediational analysis. The use of multiple comparisons for correlational analyses of the Vignette Questionnaire increased the risk of Type 1 errors occurring. This risk would have been reduced by collating the data for adult and adolescent unit staff to conduct the analyses.

The exact scoring procedure used by Crawford et al. (2003) for their Attitudes Questionnaire could not be ascertained, and it is possible that the scoring used in the current study did not mirror the original procedure, which would make comparability with the previous findings difficult. However, the scores obtained in the current study were adjusted so that total scores for each attitude dimension (effectiveness, negativity and worry) were as close to the previous study as possible, in terms of having identical maximum scores. As such a strong relationship was found between the negativity and worry scores, there is a possibility that there was a considerable overlap between the attitudes being measured.

It is important to consider that previous research that was drawn upon for this study focused on the attitudes of staff working with patients experiencing acute admissions or outpatients. The participants in the current study were staff working with patients in secure settings experiencing long-term hospitalization, whose attitudes may differ considerably to staff working in different settings.

Therefore, it may be difficult to make direct comparisons between results from staff working with different patient groups.

2.6.4 Future research

Ways of obtaining larger numbers of nursing staff participants, for example, through assuming consent to participate through return of questionnaires rather than using an Informed Consent Sheet and recruiting potential participants using other means than posted questionnaires, would be helpful in establishing the generalisability of the results found in this study. The current study only sought nursing staff participants, and future research could include participants from different professions working in inpatient settings. Any future research would be valuable in adding to what remains a very small evidence base of literature regarding self-harm in mental health inpatient settings.

In the current study, 43% of participants felt they did not receive adequate training for working with patients who display DSH. Gough and Hawkins (2000) suggested that the more training that is received the greater the perceived understanding of the client group, although research carried out in general hospital settings has produced mixed findings regarding whether training is linked to more positive or negative attitudes towards DSH (for example, McCann et al., 2006; Friedman et al., 2006). Future research could focus on detailed assessment of the training staff receive for working with DSH in inpatient settings, as well as an attempt to clarify possible links with information gathered about training and attitudes towards DSH.

2.6.5 Conclusion

The findings of this study serve to reiterate the importance of considering the potential impact that staff's views about patients who self-harm, their views about their work with such patients, and their knowledge about people who self-harm, could have upon their work and the care they provide individuals who present with DSH. Untrained nursing staff are utilised widely in these settings and yet clearly experience difficulties in feeling positive about their work with this client group. Appropriate ongoing training and support for staff who work with cases of DSH should help to increase positive views and knowledge, which could ultimately serve to improve staff retention and morale, and is likely to increase the effectiveness of inpatient intervention programmes.

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Chapter 3: Reflective Paper

Views of a Level-Headed Clinical Psychologist in Training?

Word Count: 3203

3.1 Introduction

I think I can actually say I was excited about the prospect of writing this paper. The seed of an idea was growing in my mind for some time of attempting to be more creative in my writing for this chapter of my thesis, to make a contrast from the more formal and standard formats of the literature review and empirical papers. It has often felt that my artistic bent has been subdued, or has largely been superfluous to requirements, in fulfilling the obligations necessary to get me to this point of my career in Clinical Psychology.

“...inspiration drying up

And maybe creativity.

What’s the point

In being me

If no one wants it?”

(Excerpt from reflective journal entry, 23rd August 2006)

“...her nature

Is eclipsed now.”

(Excerpt from reflective journal entry, 10th October 2006)

I wanted to allow this side of me to sneak its head above the parapet once more to write this paper, and provide the more creative and free-flowing elements that are not easy to reflect elsewhere in my thesis. In doing so, I hoped to somehow reflect the more creative skills that one may need to draw upon in clinical work,

which otherwise I feel would not have been echoed in my thesis. I have believed in the notion that studying and working in a psychological field requires the use of both cerebral hemispheres. However, the traditional idea of the left side of the brain being responsible for more logical, scientific thinking, and the right hemisphere being responsible for more abstract and artistic skills has been posited as “...simplistic at best and nonsense at worst...” (McCrone, 2000, <http://www.rense.com/general2/rb.htm>). Fink et al. (1996) did conclude that the left side of the brain is involved in interpreting details of visual stimuli whilst the right brain is involved in more global processing, only to subsequently find opposing results (Fink et al., 1997). Therefore, I think I can stand by my presumption, if perhaps more generally, that different areas of the brain are involved in different distinct processes and abilities, and I feel that working as a psychologist requires drawing upon a diverse combination of such processes and abilities, which is perhaps the nature of functioning as a scientist practitioner. I aimed to try and incorporate more creative elements to this piece of work by linking my research experiences with references from literature, music and poetry, as well as excerpts from my own poetry that comprised some entries in my reflective journal that I kept throughout the doctoral training course.

3.2 Developing Research Ideas

From very early on in the course, when I started contemplating having to carry out a piece of research for my qualification, I was interested in deliberate self-harm as a topic area. I had worked with adolescent inpatients as an Assistant Psychologist, many of whom had self-harmed, and, despite the terrible experiences the majority of those young people had endured, I was amazed to

some extent at how they could deliberately hurt themselves, as I could not comprehend being in a position when I would feel that was something I wanted to do, or felt I had to do. Because of these feelings, I initially considered the possibility of carrying out qualitative research with such patients to get their views on how staff viewed or reacted towards their deliberate self-harm. However, when I contacted professionals working in relevant settings they could provide little information about research that had been conducted in the area, and literature searching indicated that there was little existing literature on which to base any solid research ideas. However, I was still fixed on the idea of self-harm as a topic area, and my concentration moved to staff attributions, as this subject was the focus of the majority of existing literature in the area. Most previous studies centred on staff attributions towards patients presenting to Accident and Emergency departments following self-harm incidents. As I had previously worked on a mental health inpatient unit, and little attribution research had been conducted in such settings, I settled my focus on the attributions of nursing staff working within this and other units in the same setting. Pragmatically, I also considered the prospect of a large captive audience of staff who could be potential participants in this setting.

“Just look how I’m walking in all the squares!”

(From ‘Lines and Squares’ by A. A. Milne, 1924)

All in all, I feel I ended up being steered by the existing evidence base, and what felt more doable for me within the time constraints of the course deadlines. The process of narrowing down my research ideas was reminiscent of developing my undergraduate dissertation research project. At that time, I felt I plumped for less

original ideas because I did not feel confident to go with the unknown, and felt safe in adapting previous research. In many ways, I think I was “playing it safe” again when I developed my current research ideas, like Christopher Robin who avoided the unknown but presumed risk of the lines and kept to the safety of the squares on the pavement. I was also surprised by how little published research there was to be found on self-harm within mental health inpatient settings, and one aim of writing the first two chapters of this thesis was to add to this evidence base.

3.3 Stages of Research

3.3.1 Ethics

“These are just the rules and regulations...”

(From ‘Rules and Regulations’ by Rufus Wainwright, 2007)

“Learn well your grammar,

And never stammer,

Write well and neatly,

And sing most sweetly...”

(From ‘Rules and Regulations’ by Lewis Carroll, 1845)

On the whole I would describe the experience of the ethics process as frustrating. There was a lot of waiting for ethics committees’ responses, and my research did not feel under my control at this point because decisions about it seemed to be down to the people in those committees reviewing my proposal. “Going through ethics” was a new experience for me, which, with the addition of anecdotes and

hearsay about others' experiences, made me feel apprehensive about it at times. Although I did seek ethical approval for my research from the local NHS ethics committee, I did not have to seek approval from any NHS Research and Development committees as my research was being conducted in a non-NHS organisation. I was thankful for this as several of my course cohort had long and arduous waits and wrangles with such committees when seeking approval for their research. Although I personally got off lightly with my ethics experience, the process from sending my proposal to the university ethics committee through to getting ethical approval from the NHS ethics committee still took between six and seven months. Overall, the ethics experience was really like being caught between a rock and a hard place. I understand and agree that undergoing ethical review is an important and necessary requirement for proposed research. However, I am left with a lasting impression that ethics committees do not go out of their way to make this a straightforward and swift process considering the time constraints for students who are required to complete research studies within a set timeframe.

3.3.2 Gathering data

“And through Wall’s chink, poor souls, they are content

To whisper; at the which let no man wonder.”

**(Act 5 Scene 1, ‘A Midsummer Night’s Dream’, William Shakespeare, 1988
version)**

I was precluded from directly approaching staff to participate in my research because doing so may have been considered coercive. Therefore, the process of data collection through sending and receiving questionnaires felt quite impersonal,

as all I saw was the written responses of participants who returned their questionnaires. I never got to see my participants, like the mythical lovers Pyramus and Thisbe, who were forbidden from seeing each other. However, the good quality of the information provided by participants who wrote a response to the one qualitative question, “Are there any further comments you would like to make regarding your experience/feelings about working with patients who self-harm?”, suggested that those who did participate had thought about their responses and taken time over completing the questionnaires. I would have liked to have felt more involved with the participants by meeting them face-to-face to explain my research, and I may have recruited more participants as a result.

3.3.3 Statistics – left brain lacking!

I could make some parallels with carrying out statistical analysis of my data and the ethics process. It took time, although not as much as it seemed, about two months, and again felt like a slow process. My experience of research had mostly involved incorporating quantitative methods, but I had not had to carry out some of the statistical analysis before, and my design was much more complicated than I had tackled in my A-level and undergraduate psychology research projects. When it came to carrying out the data analysis, it felt like I was starting the course all over again as I experienced waves of panic about lacking adequately competent skills necessary to complete it.

3.3.4 Thoughts about future research

I did acquire a small amount of qualitative information from my questionnaire responses for my empirical research, and conducted preliminary qualitative analysis on this data. This was another new experience for me, and a refreshing

change to working on statistical packages on the computer. In hindsight I wish I had taken more of a risk with my research, and taken the plunge with using more qualitative methodology, and looked at the more innovative idea of interviewing patients or staff on their views. If future opportunities arise, I would like to be involved in carrying out qualitative research.

3.3.5 Implications for future clinical work

“I hear and I forget

I see and I remember

I do and I understand.”

(Ancient Chinese proverb by Confucius, trans. 1898)

In my literature review, I was able to make some conclusions about effective elements of interventions relevant for patients who self-harm. As a result, I think my awareness of elements that are important to consider in interventions will be heightened in my future therapeutic work. I will be inclined to consider more carefully whether particular strategies will be helpful or beneficial on the basis of the existing evidence base or formulation of the client’s difficulties. I think this reflects my progression and growth as a clinician, as I more readily question and think about work with clients in more detail on my own without such close guidance and instruction from supervisors. I think that carrying out research on staff attributions will have an impact on my future clinical work in that I will be more aware of how staff’s views of the clients they work with and their behaviour can shape how they react towards clients, and therefore potentially shape the delivery of interventions, for better or worse. As the Chinese proverb suggests, I

could only have reached these conclusions and increased awareness as a result of going through the research process.

3.4 Personal Reflections

“(...the very time you said this all
has happened once before
And thinking back through
time and circumstance,
I’m certain that it has.)”

(From untitled poem by Richard Fariña, circa 1965)

I feel that the experience of carrying out my doctoral research has mirrored my training experience overall, and was a bit of a déjà vu experience in a sense, as many of the feelings and thoughts I had in the initial months of the course were relived in going through the research process. I wanted reassurance that my work was good enough, and impatiently sought definitive answers that addressed all my questions and doubts, which were often not forthcoming or obtainable. The further I have progressed with the research, as with my training overall, I have gradually realised the less I know and I have increasingly needed to gain more knowledge, as finding out about one topic or obtaining one piece of information inevitably and simultaneously throws up several new questions. Therefore, I feel I have reached a state of “conscious incompetence” (Chapman, 2007), as I have achieved more awareness of areas in which I need to undergo further learning and development since starting my research.

“...And what you do not know is the only thing you know...”

(Extract from ‘East Coker’ by T. S. Eliot, 1944)

I distinctly remember two dreams I had some time after I had collected the data for my empirical research. The dreams focused around a baby that I had to look after, presumably my own, and it was very small and sickly. Without medical intervention and help from others I didn’t see how it could survive. There were other people around me, but no one stepped in to help, and I was left to cope with the distress and practicalities of trying to care for and help this young being. The infant appeared to be fine although it did not thrive. When I first thought about the possible meanings I could attribute to these dreams I was puzzled. I did not think that they could be a literal expression of some anxiety that I would be an incapable or inferior mother, because the prospect of motherhood had not even approached the forefront of my mind. After discussing one of the dreams with another member of my cohort as an exercise as part of a university seminar on dreams and nightmares, it became very clear to me that these dreams were reflecting some of my feelings about the research process. To be literal about it, the research was my baby that I was ultimately left holding as it was my responsibility. However, in real life I do feel I have had had ongoing support when it has been needed, from my supervisors and course staff. I think the dreams also reflected how my perceptions of the research, and perhaps often of any assessed work I had to complete, were different to those of others. Other people have been very complimentary about my work and voiced how they think I’ve been on track and well-organised, and I think I have constantly doubted my progress has been up to scratch. From reflecting on these dream experiences, I

feel I need to be able to more readily acknowledge others' positive comments about my work, and have more faith in my own abilities.

Going back to the subject of the artistic aspect of my nature, I started attending a life drawing class at the point that I had collected all of the data for my research. For some reason, until this time I did not feel I could allow myself to concentrate the time and money on such an activity. There had not been room for me to turn my attention to being artistic and creative so much at earlier stages of the research process, and now it felt like I had some freedom to do this. Once I had reached this stage of the research process, I think I took stock and reflected upon how much of my free time had been taken up doing bits and pieces of work for the thesis, and achieving balance in my life was just as important to me whether I was in the middle of my doctoral course or not. There will always be obligations that can create obstacles to achieving what one wants in life.

“It’s all coming together again now

It’s taken its time,

Or I have.

Looking after myself,

Listening to me,

What I want to do.

Being the fundamental me.”

(Excerpt from reflective journal entry, 25th October 2007)

Writing this paper has been more difficult than I imagined. It has not just required me to reflect on the research process, but to reflect on how the last two and half

years of my personal and professional life since starting my doctoral course. Reading back through the reflective journal I have kept, although sporadically, since starting the course, I was surprised how much effort I had put into reflecting on my research experiences. I thought I had only really concentrated on thinking about how events in my personal life had impacted on my work, and about anxieties and difficulties on placement. However, a significant proportion of my reflection time was spent on thinking about my research at significant moments, for example, when developing research ideas, applying to ethics committees, collecting my data, and reaching the point where I had data to analyse.

3.5 Conclusions

“I have, I am aware, told this story in a very rambling way so that it may be difficult for anyone to find their path through what may be a sort of maze...”

(From ‘The Good Soldier’ by Ford Madox Ford, 1915)

If I were to name an overarching theme of this thesis I think it would be views. The literature review highlighted how previous researchers have posited the importance of taking into account patients’ opinions about their inpatient intervention experience in relation to deliberate self-harm. The empirical paper concentrated on staff’s attributions of patients who self-harm in an inpatient environment. In this reflective paper, I have provided my viewpoint of the above and of the research experience as a whole. Reflecting upon views reminded me of one of my A-level English Literature texts, ‘The Good Soldier’ (Madox Ford, 1915), which introduced the concept of the unreliable narrator, highlighting the

fact that much evidence one receives or learns about is the presentation of someone's subjective views. Being aware of other people's views, and how they arrived at them, is therefore important, because it affects your views. Perhaps the first two chapters of this thesis could be described as a presentation of other people's views.

“The initial creative process of writing is an
aesthetic synthetic one rather than being logical
and analytic. This is the ‘artistry’ Schön said reflection
upon practice required.” (Bolton, 2003)

The requirement of including a reflective paper in my thesis has provided me with the opportunity to write more creatively, which I have greatly appreciated, probably more than the reader will appreciate the end result. (Yes I realise I still have some way to go in gaining that confidence about the quality of my work!). Writing this reflective account has reminded me of my interview day for the doctoral training course. At the time, being asked to participate in a reflective task at end of a long day of interviews and group tasks felt like a chore, but on reflection it was a valuable exercise. Since my schooldays, I have always disliked feeling a sense of anticlimax and a bit lost after exams, interviews, and after handing in my undergraduate dissertation. It is an odd feeling to have spent months on end working up to such events only for them to be abruptly over. Being asked to reflect on being challenged or completing a piece of work has provided some closure to the whole experience, and has helped it feel like a more rounded experience. Hopefully those lost sensations will not be so apparent once I have handed in this thesis. Through giving participants in my research the

opportunity to provide extra comments at the end of their questionnaires, I hoped they too would feel that they were able to say all they wanted to.

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Appendices

Appendix A – The Questionnaire Pack

Questionnaire Pack (Adult Units)

Demographics Sheet

Could you please enter the following information about yourself. You will not be personally identifiable from this information. Please do not write your name to maintain confidentiality.

Gender: Male / Female (delete as appropriate)

Profession: Healthcare Assistant

Qualified nurse – Grade:

(Tick and complete as appropriate)

Length of experience in current area of work (adult/adolescent inpatients, in months/years)

Vignette Questionnaire

You are going to be presented with a case vignette describing the case of one patient who has self-harmed, then you will be asked to answer some questions relating to what you have read. Then you will be asked some further questions about your knowledge about self-harming behaviour and attitude towards people who self-harm.

Please read the following case vignette and then answer the questions below based on your thoughts and reactions regarding what you have read.

Case Vignette

It is 1.30pm on a Thursday afternoon and you are on shift on a ward. It is very busy, patients have finished their lunch and are getting ready for different afternoon activities on and off the ward. Catherine is a 17 year-old White female with mental health difficulties, who has been on the ward for 2 months. Catherine has been fairly uncommunicative so far today, and did not eat any lunch. She is looking very pale and you notice her go and sit down on a chair. You ask her if she is feeling okay and she tells you that she has taken an overdose of tablets. You have read in Catherine’s notes that her mother died 6 months ago. This is the first time that Catherine has displayed an act of deliberate self-harm since she has been on the ward.

Now answer the following questions:

1.

Write down the one major cause of the Catherine’s act of self-harm:

.....

.....
2.

How much control do you think Catherine had over her self-harming behaviour?
(circle one number)

She had

no control over

her behaviour

1 2 3 4 5 6 7

She had

total control over

her behaviour
3.

In the future, do you think the cause of the self-harm act will continue to be present? (circle one number)

Will never again

be present

1 2 3 4 5 6 7

Will always

be present
4.

How strongly do you believe that Catherine would repeat the self-harm act?

Strongly believe

self-harm act would not

be repeated

1 2 3 4 5 6 7

Strongly believe

self-harm act would

be repeated

5. Is the cause of the self-harm act due to something about Catherine or due to something about other people or circumstances? (circle one number)

Totally due to Catherine 1 2 3 4 5 6 7 Totally due to other people or circumstances

6. How much irritation do you think you would feel towards Catherine?
No irritation at all 1 2 3 4 5 6 7 Extreme irritation

7. How much sympathy do you think you would feel towards Catherine?
No sympathy at all 1 2 3 4 5 6 7 Extreme sympathy

8. How much pity do you think you would feel towards Catherine?
No pity at all 1 2 3 4 5 6 7 Extreme pity

9. How much frustration do you think you would feel towards Catherine?
No frustration at all 1 2 3 4 5 6 7 Extreme frustration

10. To what extent do you think that your personal input on the inpatient unit would have a positive impact in reducing Catherine's self-harming behaviour in the future?
No positive impact 1 2 3 4 5 6 7 Great positive impact

11. To what extent do you think that any treatment offered to Catherine following the act of self-harm would be successful in changing her behaviour?
Not at all successful 1 2 3 4 5 6 7 Extremely successful

12. Given the busy nature of your work, is Catherine someone you would perceive as low or high priority in terms of staff time and hospital resources?
Low priority 1 2 3 4 5 6 7 High priority

13. Is Catherine someone you would be willing to offer extra time and support to in the unit you work in?
Would offer no extra time/support 1 2 3 4 5 6 7 Would offer a great deal of extra time/support

14. Is Catherine someone you would consider consulting another professional in the multidisciplinary team about to ask for their help or advice?
Would not consider consulting another professional 1 2 3 4 5 6 7 Would definitely consult another professional

15. Do you feel that you have an adequate level of the appropriate skills to deal with Catherine's act of self-harm?
Definitely do not have adequate level of skills 1 2 3 4 5 6 7 Definitely do have adequate level of skills

Knowledge Questionnaire

Now, for each statement please circle whether you think the statement is **True** or **False**.

1. Self-harm is more common in women than men
True **False**
2. People who self-harm have an increased likelihood of committing suicide in the future.
True **False**
3. Adults who have been sexually abused are no more likely to self-harm than the general population.
True **False**
4. There is no evidence that intervention by a mental health professional reduces further episodes of self-harm in severity or frequency.
True **False**
5. Behaviour modification programmes are not successful in the short term for people who self-harm.
True **False**
6. People who self-harm often have poor communication skills and low self-esteem.
True **False**
7. Self-harm is more likely to occur among adults who are socio-economically deprived.
True **False**
8. Gay men are no more likely to self-harm than the general population.
True **False**
9. Women are more likely than men to kill themselves.
True **False**
10. The majority of adults who self-harm present to health services.
True **False**
11. Adults who self-harm are usually mentally ill.
True **False**

Attitudes Questionnaire

Now, please circle the response for each statement which most closely fits with your opinion.

1. It is not useful for an adult who self-harms to have contact with me.

Strongly disagree Disagree Not sure Agree Strongly Agree

2. I have someone at work with whom I can discuss these people.

Strongly disagree Disagree Not sure Agree Strongly Agree

3. I feel hopeful that my contact with an adult who self-harms is helpful.

Strongly disagree Disagree Not sure Agree Strongly Agree

4. I think that the amount of effort I make when dealing with a person who self-harms makes a difference to the outcome.

Strongly disagree Disagree Not sure Agree Strongly Agree

5. My intervention will have no impact on adults who self-harm.

Strongly disagree Disagree Not sure Agree Strongly Agree

6. These people usually make me feel angry.

Strongly disagree Disagree Not sure Agree Strongly Agree

7. Parents of adults who self-harm usually make me feel angry.

Strongly disagree Disagree Not sure Agree Strongly Agree

8. I can empathise with parents/carers of adults who self-harm.

Strongly disagree Disagree Not sure Agree Strongly Agree

9. Neglectful parents/carers have self-harming children/relatives/partners.

Strongly disagree Disagree Not sure Agree Strongly Agree

10. Adults who self-harm waste Hospital time and resources.

Strongly disagree Disagree Not sure Agree Strongly Agree

11. If I do the wrong thing the adult who has self-harmed will kill themselves.

Strongly disagree Disagree Not sure Agree Strongly Agree

12. I rarely find myself thinking about people who have self-harmed when I am not at work.

Strongly disagree Disagree Not sure Agree Strongly Agree

13. I am worried that I am going to be blamed for what might happen to these people.

Strongly disagree Disagree Not sure Agree Strongly Agree

Just a few more questions! -

- Are there any further comments you would like to make regarding your experience/feelings about working with patients who self-harm?

.....
.....
.....
.....
.....
.....
.....
.....
.....
.....
.....

- Do you feel you receive adequate training to prepare you for working with patients who self-harm? (Please tick one answer)

Yes ☐ No ☐ Unsure ☐

- Is there any particular additional training or support that would help equip you further for working with patients who self-harm? (Please tick any options you think apply to you)

Group training session ☐

Supervision regarding working with self-harm ☐

Receive references/literature about self-harm ☐

Other ☐ Please describe

.....
.....
.....



Thank you for taking the time to complete this set of questionnaires. If you have been upset or distressed by completing them, would like some help with completing the questionnaire, or have a complaint regarding this research, and you would like to talk to someone about it then you can contact us using the details supplied at the end of the Participant Information Sheet.

All of the information and responses you have provided will remain confidential. You will be given the opportunity to receive feedback on the results of this research in due course.

Appendix B - Ethical Approval Letters

Coventry University Ethics approval form

Letter of approval from Leicestershire, Northamptonshire & Rutland NHS
Research Ethics Committee

Name Hannah Austin Payne

E-mail austinph@coventry.ac.uk

Designation / Subject & Faculty: Trainee Clinical Psychologist, Clinical Psychology Doctorate Programme, Health and Life Sciences

Title of Study: Nursing staff knowledge and attitudes towards deliberate self-harm in adults and adolescents in an inpatient setting.

1. Summary of proposal

Deliberate self-harm (DSH) is a common behaviour displayed by patients in inpatient units. Staff attitudes towards DSH have been found to influence helping behaviour towards patients who present with self-harm. Relevant factors in accordance with Weiner's attributional theory of helping behaviour, are controllability of behaviour correlated with negative affect, and stability of outcome (stability of DSH in an individual) affecting perceived optimism for success of staff input. Also, it has been found that the amount of efficacy staff perceive in their work is related to the level of negativity experienced towards patients who self-harm. Past research has tended to indicate negative attitudes from staff towards adults who self-harm, but more positive attitudes towards adolescents and young people who display DSH. The proposed study will focus on applying questionnaire measures previously used in research to a nursing staff population in an inpatient setting for adults and young people with mental health difficulties and/or learning disabilities. The aim will be to discover if further support can be found for Weiner's attributional theory of helping behaviour, and to see if there are significant relationships between negativity, effectiveness, and worry in relation to working with patients presenting with DSH. The current study also aims to ascertain whether there are any significant differences between staff perceptions of young people who self-harm and adults who self-harm. It is proposed that information on staff knowledge about DSH and qualitative information regarding relevant training needs will also be collected. Nursing staff working on units in an inpatient setting will be approached to complete a set of questionnaire measures. Findings may help inform practice by increasing awareness of factors that may influence nursing staff attitudes and intervention towards patients who self-harm, and highlighting common gaps in staff knowledge and perceived training needs of nursing staff who work with patients who self-harm.

2. Sample of participants

Nursing staff in all units for adults and adolescents with mental health needs/learning disabilities at site location

3. Site/s location

St Andrew's Group of Hospitals, Billing Road, Northampton, NN1 5DG

Tick / Cross. *"Where answered 'NO', please give reasons on separate page."*

4. Scientific background, design, method and conduct of the study

- a) Have you given a justification for the research? ☒ Yes ☐ No
b) Have you commented on the appropriateness of the design, the perceived benefits, risks and inconveniences to participants? ☒ Yes ☐ No

5. Recruitment of participants

Have you provided a comprehensive account of the characteristics of the population including the process for obtaining access as well as the inclusion and exclusion criteria? ☒ Yes ☐ No

6. Care and protection of research participants and researcher.

Have you given an account of any interventions, situations and risks which have the potential to cause harm to the participants and researchers? ☒ Yes ☐ No

7. Access, storage, security and protection of participants' confidentiality.

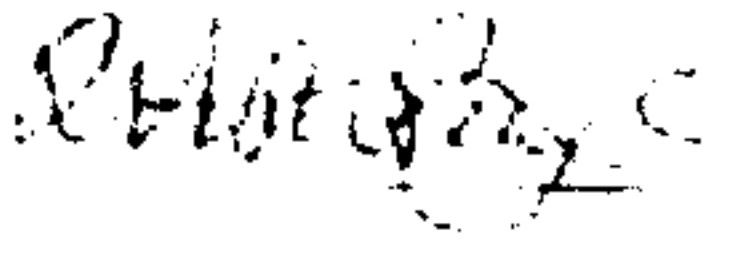


Have you identified who will have access to the data and what measures have been taken to ensure confidentiality and compliance with the Data Protection Act? ☒ Yes ☐ No

8. Informed Consent.

Have you given a full description of the process for requesting and obtaining informed consent? ☒ Yes ☐ No

9. Community considerations.

Have you considered how this study will benefit the participants or the community from which they have been drawn? ☒ Yes ☐ No

10. Participant information Sheet and consent form. Are these attached?		✓
11. Source of External Funding if any N/A		
Signature of student / staff 	Address The Old School House Gold Street Walgrave Northampton NN6 8QE	Date 17.11.06
Signature of Supervisor 	Print Name Tracey Knibbs Internal Address Clin. Psych. Cov. Uni	Date 17/11/06
Signature of Chair 	<input type="checkbox"/> Approved <input checked="" type="checkbox"/> Approved with the conditions below	Date 14/5/07
Conditions / Comments <i>Project approved with subject's consent</i> <i>Change made to subject's details</i>		

Please complete in full and return to: **Research Manager, CU Ethics Committee, Richard Crossman RCG17, Coventry University.**

This form should be accompanied by the full research study proposal or the COREC form if applicable. Further help & information can be found on W/HLS / Student / Ethics or call Rhoda Morgan on 024 7679 5945, or e mail r.morgan@coventry.ac.uk



National Research Ethics Service

Leicestershire, Northamptonshire & Rutland Research Ethics Committee 1

1 Standard Court
Park Row
Nottingham
NG1 6GN

Telephone: 01159123344 Ext: 68575
Facsimile: 01159123300

24 May 2007

Miss Hannah Austin Payne
Trainee Clinical Psychologist
Coventry NHS PCT, University of Coventry
Clinical Psychology Doctorate Programme
James Starley Building
Priory Street, Coventry
CV1 5FB

Dear Miss Austin Payne,

Full title of study: Nursing staff knowledge and attitudes towards deliberate self-harm in adults and adolescents in an inpatient setting.
REC reference number: 07/Q2501/78

Thank you for your letter of 18 May 2007, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

This Research Ethics Committee is an advisory committee to East Midlands Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application		22 March 2007
Investigator CV - Student		22 March 2007
Protocol	3	22 March 2007
Peer Review		31 January 2007
Questionnaire: Questionnaire Pack	4	18 May 2007
Participant Information Sheet	3	22 March 2007
Participant Consent Form	2	22 March 2007
Response to Request for Further Information		18 May 2007
Coventry University Ethics Committee (Form 1) - Application form for ethical approval		14 March 2007
CV - Supervisor	1	12 January 2007

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from
<http://www.rdforum.nhs.uk/rdform.htm>.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Feedback on the application process

Now that you have completed the application process you are invited to give your view of the service you received from the National Research Ethics Service. If you wish to make your views known please use the feedback form available on the NRES website at:

<https://www.nresform.org.uk/AppForm/Modules/Feedback/EthicalReview.aspx>

We value your views and comments and will use them to inform the operational process and further improve our service.

07/Q2501/78

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Dr C Edwards/Ms L Ellis
Chair/Co-ordinator

Email: Linda.ellis@nottinghamshirecounty-tpct.nhs.uk

Enclosures: *Standard approval conditions*

Copy to:

Professor Ian Marshall
Associate Pro-Vice-Chancellor
Coventry University
Priory Street
Coventry
CV1 5FB

Appendix C – Covering Letter

Coventry University
Priory Street, Coventry, CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Professor De'la Cushman
BA (Hons) MSc PhD AFBPS CPsych (Clin Foren)

THE UNIVERSITY OF
WARWICK



23rd July 2007

Dear Colleague,

You have been sent this pack as you are being asked to take part in some research that will make up part of my Clinical Psychology Doctorate. Taking part only involves completing some questionnaires, which are included in the pack. The Participant Information Sheet gives you more details about the research and taking part. St Andrew's Healthcare Research Department, and nurse managers on the units where you work, have approved this research.

If you decide to take part, please return the completed Informed Consent Sheet and Questionnaire Pack in the envelope provided and return via St Andrew's Healthcare internal mail.

Should you have any questions or concerns please feel free to contact me or my clinical supervisor using the contact details supplied in the Participant Information Sheet. Many thanks if you decide to take part.

Yours faithfully,

Hannah Austin Payne
Trainee Clinical Psychologist

Dean of Faculty of Health and Life Sciences
Dr Linda Merriman Mphil PhD DooxM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5806
Chair of Department of Psychology
Professor Koen Lamberts BA BSc MSc PhD University of Warwick Coventry CV4 7AL Tel 024 7652 3096

Appendix D - Participant Information Sheet

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702



Programme Director
Doctorate Course in Clinical Psychology
Professor Delia Cushway
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)

Participant Information Sheet

Please read this sheet before completing the Informed Consent Sheet and participating in the study by filling in the questionnaires provided.

What is this sheet about?

You are being invited to take part in a research study. Before you decide whether you want to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to other people about the study if you wish.

- Part 1 tells you the purpose of the research and what will happen if you take part.
- Part 2 gives you more detailed information about how the study is being conducted.

If there is anything that is not clear or if you would like more information you can contact us via the contact details given at the end of this information sheet. Take time to decide whether or not you wish to take part. If you do decide to take part could you please try and return the Informed Consent Sheet and Questionnaire Pack to us in the envelope provided in the next three weeks.

Part 1

What is the purpose of this study?

Deliberate self-harm (DSH) is a behaviour frequently displayed by inpatients in mental health service settings, and can be distressing to staff who witness it and intervene when DSH is displayed. Part of this study will be looking at whether attitudes towards DSH in patients differ depending on how much control the person who self-harms is considered to have over their behaviour, and how likely it is considered that self-harm will be repeated in the future (based on knowledge of previous DSH history). The study will also be looking at the factors of effectiveness, negativity, and worry experienced by nursing staff in relation to working with patients who self-harm, will be looking at staff knowledge of self-harm in the general population, and will be asking about training needs in relation to working with patients who self-harm. The study will be looking to see if there are differences in attitudes nursing staff display towards patients who self-harm depending on the patient group's age.

Dean of Faculty of Health and Life Sciences
Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7R79 F,
Chair of Department of Psychology
Professor Koen Lamberts BA BSc MSc PhD University of Warwick Coventry CV4 7AL Tel 024 7652 3096

Why is this study being carried out?

The study will make up part of a research thesis for a Trainee Clinical Psychologist studying for their Clinical Psychology Doctorate qualification at the Universities of Coventry and Warwick.

Why have I been chosen?

You have been chosen as a potential participant for this research study as a member of nursing staff working in either an adult or adolescent service unit at St Andrew's Healthcare. Any nursing staff working on these units are potential participants in this research.

Do I have to take part?

It is up to you to decide whether or not to take part. You do not have to take part if you do not wish to. If you do, can you please read this Patient Information Sheet carefully (you can keep this sheet) and complete the consent form contained in this pack. You are still free to withdraw your participation at any time without giving any reason. A decision to withdraw at any time, or a decision not to take part, will not affect your work at St Andrew's Healthcare in any way.

What do I have to do if I decide to take part?

If you do decide to take part in this study, you will just be asked to complete some questionnaires contained in this pack and return them in the addressed envelope provided via St Andrew's Healthcare internal post. It should only take approximately 25-30 minutes to complete the questionnaires, and you will not be asked to do anything else once you have completed them.

What are the possible benefits and disadvantages of taking part in this study?

Taking part in this research will provide you with the opportunity to reflect on your work with people who self-harm, to think about how your attitude towards DSH may impact on your work with patients, and to make suggestions or comments about additional training and support needs that you feel you have as a nursing staff member working with patients who may self-harm. One possible disadvantage to taking part in this research is that you may become distressed by the content of the questionnaires, which outline a fictional case of DSH and ask questions related to DSH. Contact details of people you can talk to if you experience any distress through your participation are given at the end of this information sheet.

What will happen to the information I provide?

All participant questionnaire responses will be collated for statistical analysis. All information you supply will be made anonymous for the purpose of analysing the data and writing up the report of this study, and all information you provide will remain confidential.

Part 2**What will happen if I don't want to carry on with the study?**

You can withdraw from the study at any time. If you have sent your completed questionnaire pack back to us and wish to withdraw you can do so by contacting

us via the details supplied at the end of this sheet, and we will destroy any identifiable information you supplied, but anonymous data gathered may still be used.

What if I have a concern or complaint?

If you have a concern about any aspect of this study, you should ask to speak with the researchers who will do their best to answer your questions (Contact details are given at the end of this information sheet). If you remain unhappy and wish to complain formally, you can do this through the St Andrews Healthcare Complaints Procedure. Details can be obtained from the hospital.

What will happen to the results and what feedback will I receive?

As a requirement of the qualification course to which this research will be submitted, publication of the research paper will be sought. Feedback on the results of the research will be made available to all participants following its completion through distribution of a printed feedback sheet. Also, you will be offered the opportunity to attend a presentation summarising the results of the study.

Who has reviewed the study?

This study was given a favourable ethical opinion for conduct in the private sector by Coventry University Research Ethics Committee, St Andrew's Healthcare Research Committee, and the NHS Leicestershire, Northamptonshire and Rutland Local Research Committee (LREC).

You can keep this information sheet and one copy of the signed Informed Consent Sheet will be returned to you once signed by the main researcher.

Thank you for taking time to read this sheet and thank you for your participation if you choose to take part.

Hannah Austin Payne
Trainee Clinical Psychologist

Contact Details:

Hannah Austin Payne (Trainee Clinical Psychologist) via the Clinical Psychology Doctorate Programme at Coventry University on 024 7688 8328, or write to her at:

Clinical Psychology Doctoral Programme
James Starley Building
Coventry University
Priory Street
Coventry
CV1 5FB

or contact Dr Malcolm Wheatley (Consultant Clinical Psychologist), Adolescent Services, St Andrew's Healthcare, on 01604 614339.

Appendix E – Informed Consent Sheet

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328 Fax 024
7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Professor Delia Cushway
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)



Informed Consent Sheet

After reading the Participant Information Sheet please complete and sign the following form.

I have read and understand the Participant Information Sheet. ☐

I understand that I can withdraw from the research at any time, and that I do not have to give any reasons for doing so. ☐

I understand that not taking part in the study or withdrawing at any time will NOT affect my work in the service. ☐

I understand that findings from the research will be made public, but that identifying details will be removed from the data to ensure confidentiality. ☐

I agree to take part in the research. ☐

Participant's Name:
Signed: Date:

Researcher's Name:
Signed: Date:

Dean of Faculty of Health and Life Sciences
Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory street Coventry cvi 5FB Tel 024 7670 580C
Chair of Department of Psychology
Professor Koen Lamberts BA BSc MSc PhD University of Warwick Coventry CV4 7AL Tel 024 7652 3096

Appendix F – Participant Suggestions Regarding Training Needs

Adult Service Staff Suggestions

- Wound care training
- Computer risk assessment documentation training
- Specific self-harm training for new staff who had not previously worked in mental health inpatient settings
- Group supervision discussing therapeutic skills
- Presentation/ 'Question and Answer' sessions with former or current self-harmers

Adolescent Service Staff Suggestions

- Training related to emerging Personality Disorders and self-harm
- Training on the therapeutic relationship
- Group discussion regarding specific patient cases
- Highly experienced staff sharing their experience through case studies and discussion
- Preparing new staff with no prior experience for working with people who self-harm
- Support after an incident especially if serious
- Group support & debrief
- More in-depth insight into trigger factors and distraction techniques of new patients (if information is available)
- Practical skills in cleaning and dressing wounds
- DSH training should be ongoing, delivered from time-to-time to sharpen the knowledge of staff
- Yearly training as part of mandatory training

Appendix G - Qualitative Questionnaire Responses

- I find people self-harm due to lack of self-worth, frustration or for a sense of control. I have as much time for self-harmers as for non-self-harmers, although if they complain about their wounds I have little sympathy as they are self-inflicted.
- A lot of challenge and emotionally draining, a lot of support is required at times, emotionally traumatising.
- I do not think you can understand why a person has self-harmed from a paragraph of information about them. Giving one single reason would be simplistic and would not be a good explanation of the problem.
- We as health care professionals only see a percentage of adults that self-harm, for all the clients we come across in an inpatient setting there are others that crop up in casualty depts on a regular basis that never get admitted. Also, there are even bigger numbers of adults that self-harm that nobody ever knows about, it seems to be their coping mechanism they can more-or-less control it and it never comes to light and they get on with their life.
- The hospital authority are not supporting in the efforts staff go through to help self-harmers. They adhere to red tape instead of helping the patient.
- I used to feel angry and frustrated with the patients who self-harm but experience has taught me not to.
- I have many years in various clinical settings working with people who self-harm. The most important attribute is to actively listen to what their needs are. Teaching them new strategies and mechanisms to cope is the real challenge whilst maintaining a non-judgemental but empathic response.
- The experience can be challenging at times because some patients usually repeat the self-harm behaviour. Also, it can be worrying that the patient might continue causing greater harm to themselves and even attempt suicide.
- Self-harm can be distressing to patient and staff members, when a patient burns themselves the smell is not pleasant, which can have a lasting effect on patient and staff. The severity on how the patient is so focused on hurting themselves is unbelievable and sometimes all the good will in the world cannot stop them from self-harming.
- I can empathise with patients who self-harm, as it is, in my experience, due to past history. I feel I am very lucky to have had a balanced and happy secure childhood. I can only imagine what it must be like to have been denied this. I like to think that in some small way I as a Healthcare Assistant can make a difference and contribute to their care and treatment in managing this. I have learnt over the years by watching and listening to qualified staff.

- It is very difficult for me to make very strong statements or outcomes regarding adults who self-harm because these people, as I believe, require the most important resource – time – and I don't think any of the places dealing with these people ever have enough of that resource. If only they could be consulted before they start self-harming. Once they start, the self-harming behaviour becomes a norm. Self-harmers who kill themselves at the end do so accidentally. Self-harming is nonverbal communication. The command from them is so loud but the response from us is so poor.
- Self-harm is a broad term covering many different levels and types, current approaches I feel are still relatively ineffective on long-term sufferers. Early intervention/support and education (as in most things) is the key.
- I have experience in working in self-harm environments. I have practiced behaviour management plans, DBT, and other therapies. I have worked with trauma and PTSD. Whilst stressful and emotionally exhausting, this is rewarding. The questions did not search as to the skills required or personal qualities that help staff to survive these environments. I work in the environment and opportunities to change rather than the patients.
- Catherine needs help to deal with her mother's death. Find out why she self-harmed, needs to start trusting people, when was the first time she self-harmed?, has she received treatment for her self-harm behaviours?
- I feel that with the right support and help patients who self-harm can change. People need to get to the source of a person's problems before their behaviour can be addressed (treat cause first not the symptoms). The individual has got to want help in the first instance in order to bring about change (they don't always want this in the first place).
- From the experience of working with DSH and the position I hold. I have found that many people (especially Healthcare Assistants) feel that they are to blame for patients DSH and often feel more upset when these incidences do occur in the ward.
- Although I have been working in mental health settings for years, I do not have much experience with people who self-harm.
- When I started working on the ward for the first time after leaving school. I had a very bad experience because patients were being racist and making false accusations on staff. The worst one was when a patient actually cut themselves and it freaked me out, which is another way that made me know that what you study at school is quite different from what is actually happening on the ward.
- Having worked here for 5 years my understanding for self-harm has improved and my attitude towards them is positive as I've seen patients getting better, intensity of self-harm decrease, and learning better ways to express themselves.
- It all depends on why they are self-harming to how best to support them.
- I think most people who seriously self-harm are not merely seeking attention but rather that their self-harming instincts are triggered by "forces" out of their control. There are some who come to show you or display "scratches" and would want you to feel that they have self-harmed. These are play-ups or attention-seekers.

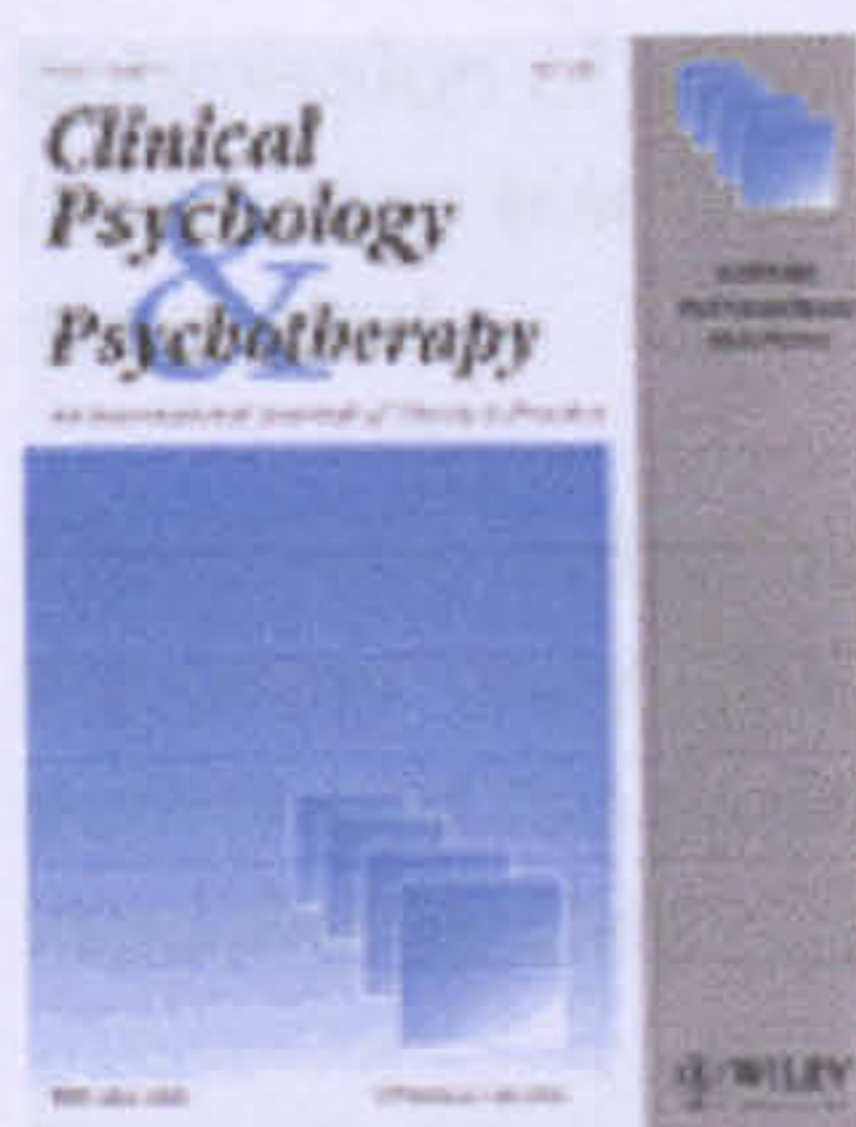
- My reactions towards people who self-harm depend very much on the environment I am in at the time and the kind of stress I am already under. I tend to find after working in the environment for a long time I have become hardened to it and find it more frustrating than anything.
- I have had some training in understanding self-harm behaviour, and how to take a positive approach.
- A self-harming patient will need to be given 24 hours monitoring and should not be taken for granted. Must not be allowed to be alone or in isolated place. Self-harming patients are always non-communicative and will always be thinking of committing suicide. The combined effort of the multidisciplinary teams goes a long way to change the seeming dangerous act of the patients. They need much of the attention of the working staff than other low risk patients.
- Working with inpatients who deliberately self-harm is quite challenging and time-consuming. You need to be totally committed and safety conscious. Constant and sudden observations of patient, i.e. safety checks, would drastically reduce the death rate of DSH in a setting of medium secure environment.
- I have experienced very strong feelings working with these patients from anger to frustration, from sadness to inadequacy, but I have also experienced the satisfaction of seeing them move on as they become more knowledgeable and skilful. To be part of that change and be allowed to share their lives for a while is very rewarding, and I try to do it with respect and humbleness.
- Not enough clinical supervision groups for Healthcare Assistants. No one to talk to about your concerns and feelings when a client has self-harmed.
- Sometimes if you think about the young people out of work it can depress you. Therefore, I try not to. When young people move on and thank you for your input, it is very rewarding and makes it worthwhile.
- There is too much risk on xxx (the units I work on) (for staff). Violent attacks on staff. It's too dangerous. It affects staff in the way that they cannot provide needed therapy.
- Self-harm/mental illness – for recovery you need support system, i.e. family (functional one) or consistent and stable community placement, without which everything is a waste and will just be going in circles – self-harm → intervention → self-harm → intervention, cycle.
- Subject to staff skill/availability, I would like to see more structured activity on the wards, to act as a distraction for these patients. In some cases, it helps to keep their minds on other things to prevent suicidal thoughts.
- These questions are too generic. Each patient is different. As a staff member the most significant factor in self-harm is intention, i.e. are they doing it for attention or relief from suffering?
- Each person will be an individual and have their own reasons for self-harm, which can be many reasons.
- When a person decides to self-harm there is very little you can do to stop them. You can distract them and get them to use their coping skills but as they described to me the pressure builds up and the only way to relieve it is to cut.

- Not enough support given after an incident. Have become hardened to the self-harming as a protective way of dealing with it. I believe there is a difference between self-harming and trying to commit suicide.
- I still find it strange that anyone derives benefit from self-harm.
- Not all young people who self-harm want to die. They do it for many reasons – you should be able to give them chill-out time if they want it, and be able to give verbal support when needed, and you can get information about self-harm from the Internet.
- From my experience I would say that self-harm is a very varied thing, which is difficult to group together. Reasons and levels of self-harm vary lots.
- I would like to think that my care and patience in looking after these young people was helpful in them coming to terms with whatever drives them to self-harm. I myself was sexually abused when I was a young child, and I would like to think my experience would help me to understand the young people.

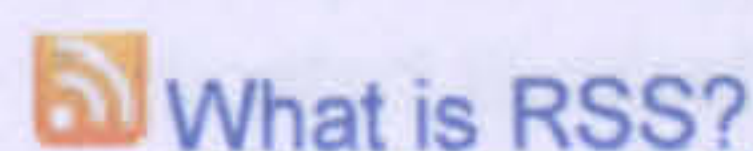
Appendix H - Notes for Contributors

Literature Review – Clinical Psychology and Psychotherapy

Empirical Paper – British Journal of Clinical Psychology



Clinical Psychology & Psychotherapy



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A. A typical citation of an entire work consists of the author's name and the year of publication .

Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.

B. If the author is named in the text, only the year is cited .

Example: According to Irene Taylor (1990), the personalities of Charlotte. . .

C. If both the name of the author and the date are used in the text, parenthetical reference is not necessary .

Example: In a 1989 article, Gould explains Darwin's most successful. . .

D. Specific citations of pages or chapters follow the year .

Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).

E. When the reference is to a work by two authors, cite both names each time the reference appears .

Example: Sexual-selection theory often has been used to explore patters of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate. . .

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Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas *et al* ., 1997) When the reference is to a work by six or more authors, use only the first author's name

followed by *et al.* in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.

G. When the reference is to a work by a corporate author, use the name of the organization as the author .

Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).

H. Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text .

Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas. . .

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Journal Article

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Book

Paloutzian, R. F. (1996). *Invitation to the psychology of religion* (2nd ed.). Boston: Allyn and Bacon.

Book with More than One Author

Natarajan, R., & Chaturvedi, R. (1983). *Geology of the Indian Ocean* . Hartford, CT: University of Hartford Press.
Hesen, J., Carpenter, K., Moriber, H., & Milsop, A. (1983). *Computers in the business world* . Hartford, CT: Capital Press. and so on.

The abbreviation *et al.* is not used in the reference list, regardless of the number of authors, although it can be used in the text citation of material with three to five authors (after the initial citation, when all are listed) and in all parenthetical citations of material with six or more authors.

Web Document on University Program or Department Web Site

Degelman, D., & Harris, M. L. (2000). *APA style essentials* . Retrieved May 18, 2000, from Vanguard University, Department of Psychology Website: http://www.vanguard.edu/faculty/ddegelman/index.cfm?doc_id=796

Stand-alone Web Document (no date)

Nielsen, M. E. (n.d.). *Notable people in psychology of religion* . Retrieved August 3, 2001, from <http://www.psywww.com/psyrelig/psyrelpr.htm>

Journal Article from Database

Hien, D., & Honeyman, T. (2000). A closer look at the drug abuse-maternal aggression link. *Journal of Interpersonal Violence*, 15 , 503-522. Retrieved May 20, 2000, from ProQuest database.

Abstract from Secondary Database

Garritty, K., & Degelman, D. (1990). Effect of server introduction on restaurant tipping. *Journal of Applied Social Psychology*, 20, 168-172. Abstract retrieved July 23, 2001, from PsycINFO database.

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